



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
New Jersey**

**Application for 2011  
Annual Report for 2009**



Document Generation Date: Saturday, September 18, 2010

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## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section.***

### **B. Face Sheet**

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

### **C. Assurances and Certifications**

Assurances and certifications are available and maintained on file in the Office of the Assistant Commissioner of the Division of Family Health Services.

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

***An attachment is included in this section.***

### **E. Public Input**

To include public input into the annual development of the MCH Block Grant Application and Annual Report, a public hearing was scheduled for June 22, 2010. A draft of the application narrative was posted on the Department's website four weeks prior to the public hearing. Notice of the public hearing was published in local newspapers throughout the State. Notification of the public hearing and availability of the draft application on the Department's website was sent to individuals on the Division of Family Health Services e-mail lists. Although only two individuals signed up to present verbal testimony and the public hearing was cancelled, 12 written letters of support were received. Written letters of testimony were all supportive of the application narrative and needs assessments. Issues in common in several written letters of testimony included: the need to improve access to quality care for children with special health care needs, the need to provide health insurance to all children through NJ FamilyCare, the promotion of the "medical home" model, and continued support for the Perinatal Addictions Preventions Prevention Program and the Access to Prenatal Care Initiative.

Input into Title V activities is encouraged throughout the year through involvement of individuals and families in the many advisory groups and task forces as described in Section III.E

## **II. Needs Assessment**

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

*An attachment is included in this section.*

### **C. Needs Assessment Summary**

This is a brief summary of the five year Needs Assessment submitted with this year's application. There have not been any recent priority changes or resource allocation shifts for the MCH population in New Jersey. There have been a number of new activities to address existing priorities which are described in the Needs Assessment and Narrative. These new activities include implementation of the Access to Prenatal Care Initiative, expansion of the Newborn Biochemical Screening Program, activities of the Governor's Council for Medical Research and Treatment of Autism, and the expansion of the Office of Nutrition and Fitness.

The selection of the New Jersey's eight priority needs is a product of FHS's continuous needs assessment. Influenced by the departmental budget process, the MCH Block Grants needs assessment process and the collaborative process with other MCH partners, FHS has selected the following eight priorities (see Section IV.B. State Priorities): SP #1 Increasing Healthy Births, SP #2 Improving Nutrition and Physical Activity, SP #3 Reducing Black Infant Mortality, SP #4 Reduction of Adolescent Risk Taking Behaviors, SP #5 Improving Access to Quality Care for CYSHCN, SP #6 Reducing Teen Pregnancy, SP #7 Decrease Asthma Hospitalizations, SP #8 Improving and Integrating Information Systems.

Some of these priorities have been longstanding priorities (SP #3 Decreasing Black Infant Mortality, SP #6 Decreasing Teen Pregnancy, SP #8 Improving and Integrating Information Systems, and SP #5 Improving Access to Quality Care for CSHCN). Others are priorities that broadly address several issues (SP #4 Decrease Adolescent Risk Taking Behaviors and SP #1 Increase Healthy Births). The remaining two priorities focus attention on more recent public health issues (SP #2 Improving Nutrition and Physical Fitness, and SP #7 Decreasing Asthma Hospitalizations).

State Performance Measures (SPM) have been changed through the new needs assessment process. Two existing SPM will be kept, five new SPM are being added, six old SPM are being deleted. The 2 existing SPM which will be continued are: Black non-Hispanic preterm infants in NJ, and children with elevated blood lead levels. The 5 new SPM are: Regional MCH Consortia conducting community-based FIMR Teams and implementing recommendations through a Community Action Team; children and adolescents who are overweight or obese; newborns who are discharged from NJ hospitals, reside in New Jersey, did not pass their newborn hearing screening and who have outpatient audiologic follow-up documented; live children registered with the BDARS who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services; and the average age of diagnosis for children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.

The 6 old SPM to be deleted are: Regional MCH Consortia implementing community-based FIMR Teams; repeat pregnancies among adolescents 15 - 19 years of age; State supported initiatives implemented for improving the nutrition and physical activity of children and adolescents; children with birth defects who are appropriately reported to the NJ Birth Defects Registry; children reported to the NJ Birth Defects Registry by three months of age; and HIV exposed newborns receiving appropriate antiviral treatment to reduce the perinatal transmission of HIV.



### **III. State Overview**

#### **A. Overview**

The Maternal and Child Health block grant application and annual report, submitted annually by all states to the Maternal Child Health Bureau (MCHB), contains a wealth of information concerning State initiatives, State-supported programs, and other State-based responses designed to address their maternal and child health (MCH) needs. The Division of Family Health Services (FHS) in the New Jersey Department of Health and Senior Services (NJDHSS), Public Health Services Branch posts a draft of the MCH Block Grant application and annual report narrative to its website each year in April to receive feedback from the maternal and child health community.

A brief overview of New Jersey demographics is included to provide a background for the maternal and child health needs of the State. While New Jersey is the most urbanized and densely populated state with 8.7 million residents, it has no single very large city. Only six municipalities have more than 100,000 residents.

New Jersey is one of the most racially and ethnically diverse states in the country. According to the 2008 New Jersey Population Estimates, 76.0% of the population was white, 14.5% was black, 7.7% was Asian, 0.3% was American Indian and Alaska Native, and 1.4% reported two or more races. In terms of ethnicity, 15.9% of the population was Hispanic. The racial and ethnic mix for New Jersey mothers, infants, and children is more diverse than the overall population composition. In 2008, 26.7% of mothers delivering infants in New Jersey were Hispanic, 46.7% were white non-Hispanic, 15.4% were black non-Hispanic, and 10.1% were Asian or Pacific Islanders non-Hispanic. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

Maternal and child health priorities continue to be a focus for the NJDHSS. The Division of FHS, the Title V agency in New Jersey, has identified improving access to health services, reducing disparities in health outcomes and increasing cultural competency of services as three priority goals for the MCH population. Specific attention has been placed on improving birth outcomes, obesity prevention, early access to prenatal care, black infant mortality reduction, reduction of risk taking behaviors among adolescents, newborn biochemical screening, autism, and improving access to quality care for children and youth with special health care needs (CYSHCN).

Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure services to meet the health of all New Jersey's families. Title V will continue to maintain a safety net of direct services, especially for children with special health care needs. During a period of economic hardship, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services.

To improve New Jersey's commitment to early prenatal care and healthy births, former Health Commissioner Howard created the Commissioner's Prenatal Care Task Force and accepted their recommendations and report in August 2008. The recommendations stressed many important goals such as increasing public awareness of preconception health; ensuring the availability of ongoing early prenatal care services for women in areas affected by hospital closures or reduction in obstetric services; and promoting equity in birth outcomes. Following recommendations from the Prenatal Care Task Force, Reproductive and Perinatal Health Services issued a competitive request for applications to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care. Nine

projects were funded within the Access to Prenatal Care Initiative representing a variety of best practice models.

To improve access to health services, the State has provided reimbursement for uninsured primary medical and dental health encounters through the designated Federally Qualified Health Centers (FQHCs) since 1992. In SFY 2009, \$5 million in state funding was again appropriated to enhance capacity of the health centers to increase primary care for underserved populations. This year there was a special focus on increasing access to prenatal care and to address the need for primary care health services in areas impacted by the closure of a hospital. In SFY 2010, reimbursement for uninsured care has remained at \$40 million.

An emerging MCH issue in NJ and nationally has been the growing obesity epidemic. In May 2008 the NJDHSS was awarded a 5 year cooperative agreement by the Centers for Disease Control and Prevention (CDC) to the Office of Nutrition and Fitness (ONF) to provide state leadership and coordination of nutrition, physical activity and obesity (NPAO) strategies. Through this cooperative agreement ONF has taken the lead in building a robust infrastructure by creating a statewide partnership of organizations and individuals, called ShapingNJ, to collaborate, build capacity and develop a comprehensive and coordinated system to halt further increases in obesity and other chronic diseases.

CDC recognizes six target behaviors for intervention to prevent or control obesity including: 1) increase breast feeding initiation, duration and exclusivity; 2) increase physical activity; 3) increase fruit and vegetable consumption; 4) decrease TV viewing; 5) decrease the consumption of sugar sweetened beverages; and 6) reduce consumption of high energy dense foods. Additionally, CDC recommends five settings for the prevention and treatment of obesity including medical/ healthcare, community, schools, childcare and the worksite. CDC requires that strategies are targeted to populations that are at risk for health disparities as indicated by data.

Priorities for the NPAO State Plan include to: 1) increase number, reach, and quality of targeted policies and standards to support a healthy lifestyle; 2) increase access to and use of environments that support healthful eating and physical activity; 3) increase the number, reach and quality of social and behavioral approaches that complement policy and environmental strategies; 4) identify data sources and monitor outcomes; 5) engage strategic public/private partnerships at the state & local level; and, 6) prioritize use of evidence-based strategies/best available evidence.

Federal American Recovery and Reinvestment Act funding for New Jersey will focus on three NPAO components including: 1) promote the initiation and duration of exclusive breastfeeding among NJ mothers; 2) improve nutrition, physical activity and decrease TV viewing for children in licensed child care centers and registered family day care homes and 3) build capacity among local health departments to implement policy and environmental change at the community level to impact obesity.

Additionally, a 5 year cooperative agreement was awarded by the CDC to the Department of Education (DOE) to collaborate with the DHSS on a Coordinated School Health Program to address nutrition, physical activity and tobacco. Three grants, each located in one of three New Jersey regions (North, Central and South), will be awarded funds to be used for the implementation of CDC's model in at least eight public middle- and/or high- schools of public school districts.

In the area of children and youth with special health care needs (CYSHCN), the Newborn Screening and Genetic Services Program helps to ensure that all newborns and families affected by an abnormal screening result will receive timely and appropriate follow-up services. All newborns receive mandated screening for 54 disorders. New Jersey is among the top 5-10 states in offering the most screenings for newborns. Follow-up services include notification and communication with parents, primary care physicians, pediatric specialists and others to ensure



the baby has immediate access to confirmatory testing and treatment. In 2008, 108,791 newborns received screening and 6,833 infants were identified with abnormal results. The Program meets and communicates regularly with several advisory panels composed of parents, physicians, specialists and others to ensure New Jersey's program is state-of-the-art in terms of screening technologies, operations and is responsive to any current concerns regarding newborn screening.

According to the Centers for Disease Control and Prevention's (CDC) 2002 prevalence figures published in the Morbidity and Mortality Weekly Report (MMWR) of February 7, 2007, one of every 94 eight year olds in the four New Jersey counties studied, had autism. As such, New Jersey has one of the highest rates of autism in the United States.

New Jersey has responded to this high prevalence rate with many legislated initiatives, administered by NJDHSS that address the needs of children and families affected by autism spectrum disorders.

The State's proposed rule for the implementation of the Autism Registry was formally adopted in September 2009. The registry includes a record of all reported cases of autism with other information deemed relevant and appropriate to (a) improve current knowledge and understanding of autism, (b) conduct thorough and complete epidemiologic surveys of autism, (c) enable analysis of this problem and (d) plan for and provide services to children with autism and their families. Reporting to the Autism Registry is done through the existing process of reporting to the Birth Defects Registry. To accommodate Autism, the BDR was expanded and is now available as the web-based Birth Defects & Autism Reporting System.

The Governor's Council for Medical Research and Treatment of Autism (the Council) has been integrated into FHS at NJDHSS and is staffed by members of FHS, Special Child Health and Early Intervention Services. The Governor's Council for Medical Research and Treatment of Autism is a 14 member, legislatively mandated Council that is charged with creating a Center of Excellence for Autism in the State where basic science and clinical research studies, as well as clinical diagnosis and treatment initiatives can take place. The Council currently has two major grant initiatives (a \$5 million dollar Biomedical Research Grant program and an \$8.55 million dollar Clinical Enhancement Center Grant program).

The Department released the Early Identification of Autism Spectrum Disorders: Guidelines for Healthcare Professionals in New Jersey in April 2009. These guidelines have been disseminated to health care professionals and members of the public to assist in evaluating infants and toddlers living in the State for autism, to ensure timely referral to appropriate services, and to provide information on the medical care of individuals with autism.

Maintaining ongoing Title V supports and services for CYSHCN and improving access to quality care for NJ CYSHCN is enhanced by collaboration with community partners. To that end, SCHEIS will work with the Statewide Parent Advocacy Network (SPAN), the NJ Academy of Pediatrics, Pediatric Council on Research and Education (PCORE), Special Child Health Services (SCHS) Case Management Units (CMUs), pediatric specialty providers and other community-based organizations on SPAN's HRSA funded Statewide Integrated Systems Grant (SIG). The SIG is providing resources and manpower to address capacity in the identification of need, coordination of care and access to information across multiple systems, data sharing, collaborating with community partners and evaluating success. In addition, NJ has been very successful in linking children registered with the Birth Defects and Autism Reporting System (BDARS) with services offered through the SCHS CMUs; Child Evaluation Centers including the Fetal Alcohol Syndrome and Alcohol Related Neurodevelopmental Disorder (FAS/ARND) Centers; Cleft Lip/Palate Craniofacial Centers; Tertiary Care Centers; and Family WRAP (Wisdom, Resources and Parent to Parent). With CDC Surveillance grant funding, the system is undergoing enhancements to support tracking of CYSHCN referred to SCHS CM, monitoring of services offered and/or provided to determine client outcomes. Information garnered from both

the SIG and CDC Surveillance initiatives is anticipated to support and enhance NJ's efforts to achieve the six core MCHB outcomes for CYSHCN.

This past year, the Early Identification and Monitoring (EIM) Program implemented the Birth Defects and Autism Reporting System (BDARS). This new electronic reporting system updated and replaced the Birth Defects, Autism, and Special Needs Registry, which has been an invaluable tool for surveillance, needs assessment, service planning, research, and most importantly is a mechanism to link families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928, and since then, linking registered children to health services. Since 1985, NJ has maintained a population-based BDR of children with all defects. Starting in 2003, the SCHS Registry received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of Autism. Subsequently, with the adoption of legislative rules in September 2009, the Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses and the Registry was renamed the Birth Defects & Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects to age 6, and added severe hyperbilirubinemia as a reportable condition. The BDARS, at present, refers all living children and their families to our SCHS Case Management Units, but does not monitor the progression into the service stream. On July 1, 2009, the first case was entered into the new web-based BDARS. EIM staff spent most of the second half of 2009 training reporting facilities on the use of the new BDARS.

New Jersey has been very successful in linking children registered with the BDARS (formerly known as the Special Child Health Services Registry) with services offered through our county based Special Child Health Services Case Management Units (SCHS CMUs). However, the System did not further track children and families to determine if and what services were offered to any of the registered children. To address this weakness, a second module is being added to the Birth Defects and Autism Reporting System (BDARS) and will be implemented in the second half of 2010. This module will be used by the SCHS CMUs to track and monitor services provided to the children and their families. It will electronically notify a CMU when a child living within their jurisdiction has been registered. Also included in the module is the ability to create and modify an Individual Family Service Plan, track services and service providers for each child, create a record of each contact with the child and child's family, create standardized quarterly reports and other reports, and register previously unregistered children.

In Fall 2009, the New Jersey Early Hearing Detection and Intervention Program (EHDI) began a new collaboration with several Federally Qualified Health Centers (FQHCs), with supplemental grant funding received from the Health Resources and Services Administration (HRSA). Three FQHCs were selected for funding that would allow them to purchase equipment and train staff to allow them to conduct outpatient rescreening for infants who did not pass their initial screening. The FQHCs will provide this service at no charge to the families, to reduce the fiscal barriers to lack of newborn hearing screening follow-up.

Another collaboration made possible by the supplemental HRSA funding was the implementation of follow-up phone calls to parents and physicians of children in need of follow-up. While EHDI rules give hospitals the primary responsibility for ensuring children receive appropriate follow-up after discharge, the level of effort put into this by each hospital varies widely. Thus this program provides supplemental contacts to compliment the hospital's outreach efforts. This outreach is being done through funding provided to the Mercer County Case Management Unit.

## **B. Agency Capacity**

This section describes Family Health Service's capacity to promote and protect the health of all mothers and children, including CYSHCN. The MCHS and SCHEIS Programs ensure a statewide system of services that reflect the principles of comprehensive, community-based,

coordinated, family-centered care through collaboration with other agencies and private organizations and the coordination of health services with other services at the community level.

The mission of the Division of Family Health Services (FHS) is to improve the health, safety, and well being of families and communities in New Jersey. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

The statutory basis for maternal and child health services in New Jersey originates from the statute passed in 1936 (L.1936, c.62, #1, p.157) authorizing the Department of Health to receive Title V funds for its existing maternal and child services. When the State constitution and statutes were revised in 1947, maternal and child health services were incorporated under the basic functions of the Department under Title 26:1A-37, which states that the Department shall "Administer and supervise a program of maternal and child health services, encourage and aid in coordinating local programs concerning maternal and infant hygiene, and aid in coordination of local programs concerning prenatal, and postnatal care, and may when requested by a local board of education, supervise the work of school nurses."

Other statutes exist to provide regulatory authority for Title V related services such as: services for children with Sickle Cell Anemia (N.J.S.A. 9:14B); the Newborn Screening Program services (N.J.S.A. 26:2-110, 26:2-111 and 26:2-111.1); genetic testing, counseling and treatment services (N.J.S.A. 26:5B-1 et. seq.); services for children with hemophilia (N.J.S.A. 26:2-90); the birth defects registry (N.J.S.A. 26:8-40.2); the Catastrophic Illness in Children Relief Fund (P.L. 1987, C370); the childhood lead poisoning prevention program (Title 26:2-130-137); and the Sudden Infant Death Syndrome (SIDS) Resource Center (Title 26:5d1-4). Recent updates to Title V related statutes are mentioned in their relevant sections.

The following is a description of New Jersey's Title V capacity to provide preventive and primary care services for pregnant women, mothers and infants, preventive and primary care services for children, and services for CYSHCN.

### III. B. 1. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal and Child Health Services (MCHS) within FHS is to improve the health status of New Jersey families, infants, children and adolescents in a culturally competent manner, with an emphasis on low income and special populations. Prenatal care, family planning, perinatal risk reduction services for women and their partners, post partum depression, mortality review, child care, early childhood systems development, lead poisoning prevention, immunization, injury prevention, oral health, nutrition and physical fitness and teen pregnancy prevention are all part of the MCHS effort.

Reproductive and Perinatal Health Services (RPHS), within MCHS, coordinates a regionalized system of care of mothers and children through the six Maternal and Child Health Consortia (MCHC). The MCHC were developed to promote the delivery of the highest quality of care to all pregnant women and newborns, to maximize utilization of highly trained perinatal personnel and intensive care facilities, and to promote a coordinated and cooperative prevention-oriented approach to perinatal services. Continuous quality improvement activities are coordinated on the regional level by the MCHC.

The Commissioner's Prenatal Care Task Force was convened by former Commissioner Heather Howard in February 2008 to improve access to early prenatal care and improve healthy birth outcomes. The Task Force's charge was to make recommendations to improve access to first trimester prenatal care in New Jersey and ultimately to increase the number of women seeking

and receiving care within the first trimester of their pregnancy. One recommendation of the Task Force was to redirect current funding to an Access to Prenatal Care Initiative. Further information about the Access to Prenatal Care Initiative to increase improve access to early prenatal care and improve birth outcomes, is provided in the Section on National Performance Measure #18.

To promote healthy births, MCHS has embraced the Fetal Infant Mortality Review (FIMR) Program as a mechanism for quality improvement. FIMR is one of the original American College of Obstetricians and Gynecologists (ACOG) Partnership projects. The overall goal of New Jersey FIMR is to establish a statewide system of fetal-infant mortality review by implementing or expanding FIMR projects with each of the six MCH consortia. New Jersey follows guidelines for planning and implementing community fetal and infant mortality review developed by the National Fetal-Infant Mortality Review Program (NFIMR). The projects use standardized data collection, entry and reporting methods to ensure consistency of the review process throughout the State. This includes using data abstraction and case review summary forms developed by NFIMR and modified by New Jersey FIMR.

The major goals of the Perinatal Addictions Prevention Project (PAPP) include providing professional and public education, encouraging all prenatal providers to screen all of their pregnant patients for substance use/abuse and developing a network of available resources to aid pregnant substance using/abusing women. Risk-reduction coordinators working with this project provide ongoing regional professional training, individual on-site training, technical assistance and monitoring, grand rounds training, networking, and a link between regional and local services relating to prenatal substance use/abuse.

Multiple studies demonstrate the benefits to both mother and infant with use of screening, assessment, and referral. NJ has adopted the 4P's Plus, designed specifically for prenatal care settings, as the screening tool that will be used. Developed by Dr. Ira Chasnoff, the questions are broadly based, highly sensitive and require only 'yes' or 'no' response. When the provider asks just six questions, it results in quick identification of patients in need of in-depth assessment or follow-up monitoring. The obstetric providers' participation in this screening project is voluntary. They screen pregnant women during their first prenatal visit and then again during their 28 week visit. The screening information is collected on a statewide basis. Approximately 25% of the pregnant women were screened for substance use during the past year. The majority of patients were seen at public clinics. Referral information is given to those women who are smoking, using drugs and/or alcohol and those who have possible domestic violence issues. Last year there were 205 education programs held for over 3357 professionals. There were 355 programs held to educate the general public and approximately 15,911 people participated.

Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. Hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period. NJDHSS offers a PPD helpline (1-800-328-3838) that operates 24 hours per day, seven days a week to provide resources and information to women and their families and friends. In addition, a dedicated Web site ([www.njspeakup.gov](http://www.njspeakup.gov)) provides educational materials such as brochures, videos, books, support groups, FAQs, and other helpful Web sites on postpartum depression and other perinatal mood disorders.

### III. B. 2. Preventive and Primary Care for Children and Adolescents

The Child and Adolescent Health Program, within MCHS, focuses on primary prevention strategies. The emphasis in Child Health is to prevent lead poisoning among children under six years of age through the collaborative, prevention-oriented outreach to parents and property owners, and the education of health care providers

The Childhood Lead Poisoning Prevention (CLPP) Project is a home visiting program providing

case management for children six years of age or younger. Twelve sites throughout the State receive funding to assess blood lead levels, immunization status, nutritional status, growth and developmental milestones, and parental-child interaction and then provide education, supportive guidance, and referral as required.

The goal of the CLPP Project is to promote a coordinated support system for lead burdened children and their families through the development of stronger linkages with Medicaid Managed Care Organizations (MCOs), Division of Youth and Family Services (DYFS), Special Child Health Services, the Department of Education, Department of Community Affairs, and other community-based agencies providing early childhood services. Only through a coordinated effort by all of these entities, along with intensive case management, will the needs of these families be addressed and preventive health strategies initiated.

Promoting healthy and safe early childhood programs is a priority for NJDHSS and its partners. In September 2005, New Jersey was awarded an Early Childhood Comprehensive Systems (ECCS) implementation grant. The ECCS Team continues to work with a myriad of public and private agencies. During 2009-2010 collaborative state partners have included the Governor's Office, the Department of Human Services, Department of Children & Families, Department of Environmental Protection, Department of Agriculture, Department of Labor & Workforce Development and the Department of Community Affairs. Current community partners have included parent support, child advocacy and early education professional development organizations, infant/child health, mental health, and special child service providers, and early education, child care and child welfare professionals.

The priority and focus of the ECCS Grant during 2009 was development of a statewide Early Childhood Health, Development and Early Learning Website, a state of the art web-based resource for consumers and professionals. The website's breakout categories have been designed to fulfill the federal ECCS grant's twelve designated key requirements for early childhood system building and provide the necessary framework for interdepartmental systems building and collaboration. The twelve key requirements include: access to care, mental and social /emotional health, early care and education/child care, parent education, family support, financing, governance, family leadership development, provider/practitioner support, communication, standards, monitoring and accountability.

The website has been designed to function as the IT gateway for all State based services and resources, for parents and caregivers of young children, and will include direct links to all 15 executive departments, the Governor's office, the legislative and judicial branches and provide interactive parent-to-parent forums, E-serve services and professional collaborative portal features. The Website is expected to go live to the public May 30, 2010.

Adolescent Health funds through June 2010 the Community Partnership for Healthy Adolescents (CPHA) initiative that addresses injury and violence (including bullying and gangs), risk behavior reduction through positive youth development approaches, and school health. Beginning July 2010, the focus of Adolescent Health will be to expand and enhance the Department of Education's (DOE) cooperative agreement with the CDC to implement the CDC Coordinated School Health (CSH) model. Successful CSH applicants, selected through a competitive application process, will be responsible for the administrative oversight, training, technical assistance and resource support for the implementation of CSH in at least eight (8) middle-and/or high schools of public school districts geographically located one each, in three New Jersey regions: Northern, Central or Southern. School districts are a required partner for this application.

School Health (SH) Specialists, hired by the successful applicant will collaborate with a School Health (SH) Coordinator identified by the school district partner. The SH Coordinator will ensure the implementation of required school health activities and assure that the activities, funded by this grant, align with State goals and project objectives. As a result of participation, the school

district partner is expected to progressively expand the implementation of CSH district-wide. Collaboratively, the DHSS with its three successful applicants and their school district partners will join the Department of Education's (DOE) New Jersey CSH Demonstration Project in serving as the proactive leaders to mobilize New Jersey's expansion of CSH statewide.

The goals for this pilot project are to increase the number of schools that are using CDC's CSH model to: 1) address the physical, emotional and social well-being of their students, 2) create opportunities for healthier choices by students and school staff through environmental or policy change strategies, and 3) strengthen and sustain state and school district capacity to support a coordinated school health system through effective leadership, strategic partnerships, youth engagement, funding development and the use of data-driven and best practices or evidence-based programs.

The NJDHSS established the New Jersey Children's Oral Health Program in 1981. The Program provides a variety of oral health education activities for children in grades pre-K through 12. The Program is regionally implemented in all 21 counties of the State with each region having an Oral Health Coordinator and other program personnel that implement program activities. Educational activities are age-appropriate and cover a variety of oral health issues including, but not limited to, good oral hygiene, fluoride as a preventive measure for tooth decay, dental sealants, nutrition, periodontal disease, tobacco cessation, and the prevention of oral trauma. Classroom presentations include discussion, audio-visual materials, and extensive student participation. All Children's Oral Health Program activities can be adapted for an audience of children with special needs. Educational presentations are also provided to parents and pregnant women. Furthermore, the program staff provides in-service or workshop programs to non-dental professionals, including school nurses, public health nurses, teachers, WIC Coordinators, and social workers. During the 2008-2009 school years, over 80,000 individuals participated in formal oral health education programs provided by the Regional Oral Health Coordinators and their staff.

### III. B. 3. Preventive and Primary Care for Children with Special Health Care Needs

Special Child Health and Early Intervention Services (SCHEIS) ensures that all persons with special health needs have access to comprehensive, community-based, culturally competent and family-centered care. NJ administers programs and services through the Family Centered Care Services (FCCS) Unit that ensure access to comprehensive, family-centered, culturally competent, community-based care for children age birth to 21 years of age with special health care needs. These programs partially support 21 county-based Special Child Health Services Case Management Units (SCHS CMUs), one Family Support project, 11 Child Evaluation Centers (CECs) of which six house Fetal Alcohol Syndrome Disorder Centers, and five Cleft Lip/Palate Craniofacial Anomalies Centers of which three also provide newborn hearing screening follow-up and three Tertiary Care Centers. Seven Ryan White Part D (RWPD) Family Centered HIV Care Network Centers are also administered through FCCS and serve clients across the age span. They are funded by the HIV/AIDS Bureau, collaborate across programs and link with Title V programs and services, as needed.

A priority for SCHEIS is ensuring rehabilitative services for blind and disabled individuals less than 16 years old receiving services under Title XIX. Historically, SCHEIS has addressed the early identification, outreach to and the support of that special needs population through follow-up of CYSHCN by the SCHS CMUs. Typically, CYSHCN age birth -- 21 years of age are identified to the SCHS CMUs in the county in which the CYSHCN resides through the BDARS and the Catastrophic Illness in Children Relief Fund; by community, family and self-referrals; and through the Social Security Administration (SSA).

A recent change in the process by which SCHEIS has streamlined SSA referrals to the SCHS CMUs is facilitating timely access to comprehensive care. The SSA referral system has moved from paper to electronic transmission. The DHSS uploads monthly county specific reports which

are then viewable by the SCHS CMUs through the DHSS' secured web access. The SCHS CMUs outreach to all CYSHCN referred by SSA to offer information and referral; development of an individualized service plan; case management services as needed; linkage with community-based primary and pediatric specialty care, transition to adulthood, family support and social service supports across local, State, and federal programs. This electronic referral system eliminates the need and cost to mail SSA reports, leaving only a minimum number of paper reports received from Disability Determinations needing to be mailed to the SCHS CMUs for follow-up. With electronic access to their county specific reports, the SCHS CMUs manage their workflow. In addition, receiving the data electronically has enabled SCHEIS to more accurately track the numbers of CYSHCN referred and served. In 2009, 13,810 CYSHCN were referred versus 7,700 in 2008 (44% increase in total unduplicated referrals); and 7,348 CYSHCN served in 2009 versus 4,600 in 2008, (60% increase in unduplicated served). In 2009, 22% (2,350) of the 10,500 active children with Individual Service Plans served statewide through the County Case Management Units were identified as Supplemental Security Income (SSI) beneficiaries.

SCHEIS partially supports hospital-based out-patient rehabilitative services for CYSHCN including blind and disabled CYSHCN under the age of 16 receiving benefits under Title XVI. The Specialized Pediatric Services providers include Child Evaluation Centers, Tertiary Centers and Cleft Lip/Cleft Palate Craniofacial Anomalies Centers. Over 11,000 encounters of specialty and/or subspecialty services were reported statewide. In review of 2009 program data on client encounters by units of service, the majority of encounters (34%) were with a cardiologist, followed by neurologist (33%), gastroenterologist (32%), immunologist/allergist (32%), pulmonologist (23%), nephrologist (14%) and urologist (10%). The Centers provide evaluation and/or treatment for CYSHCN, and ensure access to care regardless of ability to pay. These health service grantees are expected to make a reasonable effort to collect payment for services rendered, however no CYSHCN is denied care because of inability to pay. The Centers are noted as Centers of Excellence by NJ Medicaid. They accept NJ Medicaid, Medicaid Managed Care, NJ Advantage, commercial insurance and/or payment on a sliding-fee commensurate with the SCHEIS Fee-for-Service/NJ Charity Care guidelines.

To ensure family participation and address cultural competency, the Centers provide written informed consent guidelines for all aspects of the evaluation, diagnostic and/or treatment services. The confidentiality of records is protected, written procedures regarding access to records is made available to all staff, and the sharing of records is determined by the parents of CYSHCN. Each Center maintains written procedures for parental consent for release of records. The Centers must comply with the Americans with Disability Act (ADA) requirements. Limited English proficiency needs are addressed through access to foreign language interpreters and/or interpreters for the deaf. The Centers cannot discriminate through admission policies, hiring practices, or promotional opportunities on the basis of race, religion, ethnic origin, sex or handicapping conditions. CYSHCN with ongoing needs that warrant care coordination are linked with the SCHS CMU located in their county of residence.

Upon receipt of referral the SCHS CMUs conduct outreach to determine CYSHCN's needs and with parent input develop an Individual Service Plan (ISP). The ISP addresses medical, dental, developmental, rehabilitative, social, emotional, and economic needs of the CYSHCN and/or the family as related to the child's needs. Periodic monitoring of needs and progress toward attaining services are also conducted.

In 2009, nearly 9,000 hard copy BDARS referrals were received by the SCHS CMUs. Likewise, the SCHS CMUs report new or revised data to the BDARS on a paper form. In an effort to improve efficiency, the BDARS is collaborating with the State SCHS Case Management program to develop a web based reporting and tracking system. This mechanization is eagerly anticipated to improve accuracy in reporting and tracking.

Funded by the HIV/AIDS Bureau Ryan White Part D and housed in FCCS, the NJ Statewide Family Centered HIV Care Network provides a full range of high quality, culturally sensitive and

coordinated HIV/AIDS medical and social support services to women, infants, children, and adolescents infected with or affected by HIV disease. The Network's vision of family health builds on an innovative integration of clinical, research, and educational services to provide the best family care possible. For over 22 years, Network physicians and staff have been at the forefront of HIV care and are committed to improving the quality of life for people living with HIV disease. The target population served by the Family Centered HIV Care Network includes women, infants, children, and youth, and their affected family members. In 2009, 3,601 clients were served. African Americans account for 68% of the clients served, and Latinos account for 22% of the clients served. New Jersey's experience in serving children and youth indicates that the number of HIV infected newborns and children has steadily decreased in the past five years, while the number of HIV infected adolescents has steadily increased over the same time period. In addition to collaboration with Title V MCCH and SCHEIS services and programs, the NJ Ryan White Part D program has the lead responsibility for implementing the federal HRSA Ryan White Quality Management Cross-Part Collaboration Project. Development and implementation of the plan from collaborating with the cross title NJ team and providing technical assistance on data collection has been ongoing to the Ryan White grantee agencies statewide.

For approximately 20 years, SCHEIS has worked with parent groups, specialty providers and a statewide network of SCHS CMs to provide family-centered, community-based, coordinated care for Children and Youth with Special Health Care Needs (CYSHCN) and facilitate the development of community-based services for such children and their families. The Statewide Parent Advocacy Network (SPAN) funded through SCHEIS provides parent support through a three-pronged approach titled Family WRAP (Wisdom, Resources, Advocacy and Parent-to-Parent). Specific Family WRAP programs include Project Care, Parent-to-Parent and Family Voices New Jersey.

SPAN and SCHEIS have continued to collaborate to identify resources to expand the number of Resources Specialists (trained support specialists) on site at the SCHS Case Management Units particularly in the southern New Jersey counties. Through the federal Parent Training Information Center (PTI) funding, the additional five Parent Resource Specialists continue to be housed in Cape May, Cumberland, Burlington, Salem and Gloucester Counties. This collaborative initiative maintains the total of case management units with part-time onsite family support to 15 counties and additional telephone support to the remaining 6 county units. Funding is being sought to further expand on-site parent support at the remaining counties through a 2009 HRSA sponsored State Implementation Grant, and notice remains pending on that application.

In an effort to enhance family support capacity the SCHEIS collaborated with SPAN, the NJ Academy of Pediatrics Pediatric Council on Education and Research (PCORE), and other community partners to develop grant applications for supplemental funding. Recent successful collaborations with SPAN include the HRSA Statewide Implementation Grant for Integrated Community Systems (SIG), and the Administration on Developmental Disabilities' Military 360 initiative for military families at the combined Fort Dix McGuire Air Force Base and Lakehurst Naval Air Station mega-base.

### **C. Organizational Structure**

All Maternal and Child Health (MCH) programs including programs for Children and Youth with Special Health Care Needs (CYSHCN) are organizationally located within the Division of Family Health Services (FHS). All Title V services are under the direction of Celeste Andriot Wood, Assistant Commissioner, Division of FHS.

A organizational chart for the NJDHSS is attached to this section.

A organizational chart for the Division of Family Health Services is attached to the next section Other MCH Capacity.



***An attachment is included in this section.***

## **D. Other MCH Capacity**

The following section describes the number and location of staff that work on Title V programs.

### **Maternal and Child Health Services (MCHS) Unit**

Maternal and Child Health Services (MCHS) is comprised of three program managers, 24 professionals, and 14 support staff. All staff members are housed in the central office. Dr. Lakota Kruse is the Service Director for MCHS. Dr. Kruse is a Pediatrician and an MCH Epidemiologist who has been with the NJDHSS since 1993. Among the professional staff are individuals with nursing, social science, environmental, nutrition, statistical, epidemiology, and other public health backgrounds.

Reproductive and Perinatal Health Services is staffed by 10 professionals and 3 support personnel and a Program Manager, Sandra Schwarz RNC,MS. The program is responsible for the regional MCH Consortia, Healthy Mothers, Healthy Babies Coalitions, Certificate of Need rules and MCH Consortia regulations, morbidity and mortality reviews, Healthy Start projects, Family Planning, the Black Infant Mortality Reduction Initiative, perinatal addictions and fetal alcohol syndrome prevention projects, post partum mood disorders initiative, Access to Prenatal Care Initiative, and preconceptional health. Resources for staff have been from Federal MCH Block, Federal Title X, Preventive Health and Health Services Block, and Healthy Start Grants.

Child and Adolescent Health is comprised of a staff of 7 professionals, 5 support personnel, 1 paraprofessional and a Program Manager, Cynthia Collins. Resources include: State MCH funds, Federal MCH, and Preventive Health and Health Services Block Grants, Centers for Disease Control and Prevention cooperative agreements for Lead and School Health, an Early Childhood Comprehensive Systems (ECCS) Implementation grant from HRSA, MCHB and State Lead funds. All staff members are housed in the central office. Child and Adolescent Health has oversight by a Program Manager with responsibilities that address childhood lead poisoning and prevention and adolescent health in middle and high schools. Childhood lead poisoning and prevention has one Primary and Preventive Health Services Coordinator, four professionals and 1 paraprofessional. The Health Resources and Services Administration (HRSA) funds New Jersey's Early Childhood Comprehensive System grant and its activities are coordinated by one professional staff position. Adolescent health currently includes the Community Partnership for Healthy Adolescents initiative and the Centers for Disease Control's Coordinated School Health model and is staffed by two professional positions. Child and Adolescent Health staff have varied professional backgrounds including nursing, nutrition, health education, research and data analysis.

To build state and local capacity for addressing the health and development needs of children and adolescents through coordinated school programs the NJ Department of Education (NJDOE), in partnership with the NJDHSS, applied for and was awarded a five-year cooperative agreement in March 2008 by the Centers for Disease Control and Prevention (CDC.) A portion of the CDC funding is allocated to NJDHSS, through a Memorandum of Agreement, for one full-time equivalent professional position that functions as the DHSS School Health Coordinator.

Adolescent Health released in February 2010 a competitive Request for Applications for organizations interested in applying for "Building a Coordinated School Health (CSH) System in New Jersey". Three grants, each located in one of three New Jersey regions (North, Central and South), will be awarded funds to be used for the implementation of CDC's model in at least eight public middle- and/or high- schools of public school districts, for a total of at least 24 schools. It is the intent of this grant to provide funds for a three year pilot project period; however, budgets will be annually submitted and approved.

In May 2008, two months after the award of the CDC cooperative agreement with the NJ Department of Education (NJDOE), the NJDHSS was awarded a 5 year CDC cooperative agreement to the Office of Nutrition and Fitness (ONF) for state leadership and coordination of nutrition, physical activity and obesity strategies (NPAO). Through this cooperative agreement, DHSS will collaborate with the existing infrastructure, which includes NJDOE, the Department of Agriculture, the Department of Transportation (DOT) and the Department of Children and Families (DCF) for the implementation of state determined strategies focused in the school venue to prevent obesity.

The Children's Oral Health Education Program comprised of 1 professional and 1 support staff reports to the Office of the Director. Dr. Beverly Kupiec-Sce coordinates the program which provides age appropriate oral health education to school age children.

The mission of the Maternal and Child Health Epidemiology Program (MCH Epi) is to promote the health of pregnant women, infants and children through the analysis of trends in maternal and child health data and to facilitate efforts aimed at developing strategies to improve maternal and child health outcomes through the provision of data and completion of applied research projects. The MCH Epi Program promotes the central collection, integration and analysis of MCH data. MCH Epi is comprised of three research professionals, and two support staff. All research staff members possess extensive experience in statistics, research, evaluation, demography and public health. Additionally, professional staff members have extensive experience with data linking, record matching and epidemiological research. One professional staff position is supported entirely by resources from the MCH Bureau's State Systems Development Initiative (SSDI) grant. The Pregnancy Risk Assessment Monitoring System (PRAMS) survey is coordinated by the MCH Epi Program. Ingrid Morton is the Program Manager for MCH Epi. The MCH Epi program was integrated into the MCHS Unit in April 2010.

The Office on Nutrition and Fitness (ONF) within FHS consists of a Director, Peri Nearon, with 7 professional staff and 1 secretarial support staff. Funding sources include: a Centers for Disease Control and Prevention cooperative agreement for Nutrition, Physical Activity and Obesity (NPAO) and state MCH funds. All staff members are housed in the Division of Family Health Services. In addition to the CDC cooperative agreement for NPAO, the Office also includes the Healthy Community Development Leaders' Academy and mini grants. ONF is responsible for addressing obesity prevention throughout the lifecycle. ONF staff have varied professional backgrounds including nutrition, public health, environmental studies, research and data analysis.

#### Special Child Health and Early Intervention Services (SCHEIS)

Special Child Health and Early Intervention Services (SCHEIS) consists of the following programs and services: Early Identification and Monitoring, Newborn Screening and Genetic Services Program, Family Centered Care Services, Early Intervention System and the Autism Program. Gloria Rodriguez is the Director of SCHEIS. All SCHEIS staff members are housed in the central office.

The Early Identification and Monitoring (EIM) Program is responsible for the reporting and monitoring of children with birth defects and special needs (the Special Child Health Services Registry), and Autism, and the Early Hearing Detection and Intervention Program. The EIM Program is comprised of a staff of ten professionals, seven support staff, and a Program Manager, Leslie Beres-Sochka, who holds a Master of Science in biostatistics and has over 20 years experience in research, statistical analysis, and database design and management. Resources for staff come from the MCH Block Grant, a HRSA grant for universal newborn hearing screening, and two Centers for Disease Control and Prevention cooperative agreements (EHDI and Birth Defects Surveillance), and the Autism Medical Research and Treatment Fund.

The Autism Program encompasses the various autism-related activities within SCHEIS. The Medical Director of the Autism Program, Lorraine Freed Garg, MD, MPH, is responsible for coordinating collaborations between the autism-related activities in SCHEIS, including those conducted by the Early Identification and Monitoring Program, the EIS program, and the Governor's Council for Medical Research and Treatment of Autism (the Council). In addition to facilitating these collaborations, the Medical Director also directly oversees the initiatives and activities of the Governor's Council for Medical Research and Treatment of Autism, a council that receives funding from state monies. The Council's initiatives include a large research grant program as well as the Clinical Enhancement Center Grant Program, a program which enables 6 clinical centers to enhance their autism diagnostic and treatment services, in part through improving the early identification of children on the autism spectrum, conducting a larger number of multi-disciplinary evaluations for autism, and decreasing wait time for receipt of these evaluations.

The Newborn Screening and Genetic Services Program is responsible for the follow-up of newborns with out-of-range screening results. This program also provides partial support through its grants to specialty care centers and facilities for metabolic and genetic services, pediatric endocrine services, pediatric hematologic services, pediatric pulmonary services and specialized confirmatory and diagnostic laboratory services. The Newborn Screening and Genetic Services Program is currently comprised of a staff of 8 professionals and two support staff and a Program Medical Director, Dr. Marilyn Gorney-Daley, DO, MPH.

The Family Centered Care Program (FCCP) is responsible for funding, monitoring, and evaluating services provided by the 21 Title V funded case management units, Family WRAP family support services, 11 child evaluation centers which include 6 FAS Diagnostic Centers, 5 cleft lip/cleft palate centers, 3 tertiary care centers, two organ donor and tissue sharing donor awareness education programs, and the 7 Ryan White Part D funded Statewide Family Centered HIV Care Network sites. Resources for staff come from the MCH Block Grant and from the HRSA AIDS Bureau under Ryan White Part D. This program is comprised of a staff of seven professionals, three support staff, and a Program Manager, Mrs. Pauline Lisciotto, RN, MSN. The Coordinator of Special Child Health Services, Case Management is Mrs. Bonnie Teman, RN, MSN.

The Early Intervention System is headed by Terry Harrison, Part C Coordinator. This System provides services to infants and toddlers with disabilities or developmental delays and their families in accordance with Part C of the Individuals with Disabilities Education Act.

All programs within SCHEIS have staff with varied professional backgrounds including nursing, medicine, physical therapy, epidemiology, speech pathology, public health, research, statistics, family counseling, education, and genetic counseling. Both senior level and support staff includes parents of children with special health care needs such as developmental delay, seizure disorder, specific genetic syndromes, and asthma.

***An attachment is included in this section.***

## **E. State Agency Coordination**

This sections describes relevant organizational relationships between FHS and the State Human Services agencies (mental health, social services/child welfare, education, corrections, Medicaid, SCHIP, Social Security Administration, Vocational Rehabilitation, disability determination unit, alcohol and substance abuse, rehabilitation services); the relationship of State and local public health agencies (including MCH Consortia) and federally qualified health centers; primary care associations; tertiary care facilities; and available technical resources which enhance the capacity of the Title V program.

This section also describes the plan for coordination of the Title V program with (1) the Early and

Periodic Screening, Diagnosis, and Treatment Program (EPSDT), (2) other federal grant programs (including WIC, related education programs, and other health, developmental disability, and family planning programs), and (3) providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for services.

New Jersey has prided itself on its regional MCH services and programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. The consortia are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs. Specific programs include the activities of the Access to Prenatal Care Initiative, eight Healthy Mothers Healthy Babies Coalitions, Perinatal Addictions Prevention Projects, Post Partum Depression education projects, preconceptional health counseling, regional Childhood Lead Poisoning Prevention Coalitions, and facilitation of the Black Infant Mortality Reduction Initiative.

A representative from Reproductive and Perinatal Health Services serves as the liaison to two of the NJ Healthy Start Projects and is responsible for the collaboration and coordination of the New Jersey Healthy Start Projects with Department activities and programs. This collaboration helps to assure integration of services and the effective use of both State and Healthy Start funds to eliminate disparities in women's and infant's health.

Promoting healthy and safe early childhood programs is a priority for NJDHSS and its partners. In September 2005, New Jersey was one of 18 states that were awarded an Early Childhood Comprehensive Systems (ECCS) implementation grant. The focus of the ECCS Grant during 2009 was development of a statewide Early Childhood Health, Development and Early Learning Website, a state of the art web-based resource for consumers and professionals. During 2010-2011 the focus of the ECCS grant will continue to be the website. The goal of the website and portal will be to improve the accessibility, coordination and delivery of information and services to children and their families, and to improve the communication capabilities for ongoing service collaborations and policy development.

Following completion in June 2010 of the website and portal, early childhood systems building efforts will continue with the rebuilding and expansion of the NJ ECCS Team. The NJ ECCS team will sustain the active communication and systems networking necessary to maintain NJ early childhood health, development and early learning goals and will include a total of 150 representatives from all 15 executive departments, the governor's office, the legislative and judicial branches, as well as community stakeholders. The team is expected to include 15 (10%) parent representatives.

School health collaboration and coordination is accomplished through a school health liaison position within the Adolescent Health section. The Departments of Education and DHSS staff have developed joint statements and a Strategic Plan for School Age Health signed by both Commissioners. The strategic plan affirms both departments' support for comprehensive school health programs, with a particular focus on the 31 special needs school districts.

To address school health and adolescent risk taking behavior, DOE formalized a partnership with DHSS, through the use of a MOA, for implementation of CDC's Coordinated School Health (CSH) model. In addition to DOE and DHSS, there is state department representation from: Agriculture (NJDA); Children and Families (DCF) School Based Youth Services Program, Environmental Protection (DEP), the Juvenile Justice Commission (JJC) and Transportation's (DOT) Safe Routes to School.

State department stakeholders met in September of 2008 to create the five-year Strategic Plan. Essential components of this plan included the identification of program strengths, weaknesses, threats and opportunities as well as six School Level Impact Measures (SLIMS): three in the area

of Coordinated School Health, and one each in the programmatic areas of physical activity, nutrition and tobacco.

The Children's Oral Health Program is administered is organized into three regional programs (north, central and south) and covers all twenty-one counties of the State. Program services are targeted to high-need/high-risk areas with non-fluoridated community water and work with schools with a high proportion of students enrolled in free-and reduced lunch programs (children from low-income families). All three regional programs have similar scope of services and the programs provide the same types of activities. Through a Memorandum of Agreement with the State's dental school, the University of Medicine and Dentistry of New Jersey, New Jersey Dental School, a licensed dentist is available to provide dental consultation to the Program.

Coordination between the State's Primary Care Association and Federally Qualified Health Centers continues. The Coordinator of Primary Care works out of the Office of Primary Care. The Federal Primary Care Cooperative Agreement is administered by this office. The Office of Primary Care has provided cost-base reimbursement to qualified FQHCs for eligible visits by uninsured and underinsured individuals since 1991. Funds to compensate the centers for uninsured visits are derived from the Health Care Subsidy Fund, which is financed by an assessment on hospital operating revenues. The portion of the annual assessment that is allocated to the FQHCs is \$40 million in SFY 2010 and \$40 million in SFY 2011.

The FQHCs operate in 20 of NJ's 21 countries. The 20 FQHCs have a combined 95 licensed satellite sites throughout the State. As a consequence of expansion and capacity building initiatives overall growth in the number of uninsured visits reimbursed has been exponential. In 2009, almost 150,00 uninsured persons were services and over 4000,000 uninsured visits reimbursed. Overall, there were almost 400,000 patients and over 1 million visits provided by the state's network of FQHCs. Capacity of the FQHCs has expanded in evening and weekend hours. The average FQHC site is operational 47 hours per week. All FQHCs operate "call coverage" services. Some FQHCs provide "urgent care" programs that extend far beyond the normal work day, thus allowing patients access to care in a primary care setting as opposed to a hospital emergency department.

The NJ Title V CYSHCN program collaborates with programs and services across State government to facilitate access to coordinated, comprehensive, culturally competent care for CYSHCN. The Department of Human Service (DHS) is the largest department in NJ State government, and although Title V collaborates with many of its health programs and support services, those directly addressing medical, dental, developmental, rehabilitative, mental health, and social service are essential. Title XIX and Title XX services are administered by DHS, and provide critical supports for ensuring access to early periodic screening detection and treatment for CYSHCN. The State DHS Medicaid, Children's Health Insurance Program Reauthorization Act (CHIPRA) NJ FamilyCare program, and the Division of Disability Services afford eligible children comprehensive health insurance coverage to access primary, specialty, and home health care that CYSHCN and their families need.

On the local level, the SCHEIS programs, SCHS CMUs, SPS, and RWPDP, screen all referrals for insurance and potential eligibility for Medicaid programs, counsel referrals on how to access Medicaid, NJ FamilyCare, Advantage, and waiver programs, and link families with their county based Boards of Social Services and Medicaid Assistance Customer Care Centers. They collect and report program data including insurance status. That report is compared with Medicaid data in determining CYSHCN need. Referrals are made to Boards of Social Services, NJ Family Care, Advantage, Charity Care, Department of Banking and Insurance, and Disability Rights NJ for supports/advocacy.

The Division of Family Health Services (FHS) maintains a memorandum of agreement with the DHS Medicaid to facilitate operation of the SCHEIS Fee-for-Service program. It ensures access to medications for the treatment of children with asthma and cystic fibrosis through NJ Medicaid

participating pharmacies. Children birth to 21 years of age referred for this program are linked with the SCHS CMU in their county of residence for intake, information and referral, individualized service plan development, intermittent monitoring of needs, and registration with the BDARS. Likewise, State DHS staff that administer Medicaid durable medical equipment services and SCHEIS Fee for Service staff collaborate on technology and resource trends related to hearing aids, braces and orthotics.

The State SCHEIS office collaborates with DHS offices and programs to develop and implement policy that will ensure that children referred into the SCHS CMUs and their families are screened appropriately for healthcare service entitlements and waived services. 100% of CYSHCN served through SCHS programs; SCHS CM, Pediatric Specialty Care Providers (SPS) including Child Evaluation Centers (CECs), Cleft Lip/Palate, Craniofacial Anomalies Centers and Tertiary Care Centers as well as the Ryan White Part D Family Centered HIV Care Network are screened for insurance status and/or referred for Medicaid/NJ FamilyCare or waiver programs, as applicable.

The DHS Office of Medicaid Managed Care (MMC) Quality Assurance is helpful in ensuring that families of CYSHCN are accessing comprehensive quality managed care, and that specialty providers are enrolled and coding correctly. Periodically, ad hoc committees are convened to problem solving provider reimbursement questions.

In 2010, major changes are occurring in NJ Medicaid Managed Care, with two of the Medicaid health maintenance organizations acquiring two other currently existing plans and a new HMO being awarded. Over a six month period, 100,000 Medicaid managed care enrollees are targeted to change health plans. To facilitate this process SCHEIS is collaborating with the Office of Medicaid Managed Care Quality Assurance to provide outreach and support to families and specialty providers.

The DHS disability specific programs facilitate access to comprehensive care and supports for CYSHCN. Likewise, they commonly consult with State SCHEIS staff and our network of providers to ensure that families are linked to specialty services. Blind and/or visually impaired CYSHCN are referred to the DHS Commission for the Blind and Visually Impaired (CBVI). The CBVI staff provides itinerant education services for infants and toddlers age birth to 3 years of age and their families. Visually impaired children age 3-21 years, and deaf/blind CYSHCN age birth-21, are referred for assessment and evaluation of visual abilities, instruction in Braille and related skills, family supports, educational supports, adaptive aids and texts, assistive technology, and other supports.

The DHS, Division for the Deaf and Hard of Hearing (DDHH), partners in planning access to care and service delivery for CYSHCN with impaired hearing. The State SCHEIS staff and DDHH staff cross refer CYSHCN and their families for services and supports. Advocacy, employment and vocational opportunities, sign language interpreter services and assistance with social, legal, medical, educational, and recreational issues are examples of services that SCHS CM and the Specialized Pediatric Services providers refer CYSHCN to DDHH. The DDHH also publishes a monthly newsletter that provides updates on newborn hearing screening, Grace's Law, and SCHEIS programs.

The Early Identification and Monitoring (EIM) Program has multiple collaborations with the Division of the Deaf and Hard of Hearing (DDHH), in the New Jersey Department of Human Services (DHS). The EIM Program Manager is the DHSS representative on their Advisory Council. She and her staff have presented information concerning the BDARS, EHDI, and Autism to the council on numerous occasions. DHSS has partnered with DDHH on numerous outreach programs for consumers, and printed brochures. The EHDI program collaborates with DDHH on the organization of a biennial conference for families of children with hearing loss.

Collaboration between SCHEIS State staff, SCHS CM and/or Specialized Pediatric Services

providers and the DHS, Division of Family Development (DFD) is essential in coordinating access to care and social services for many of NJ's most vulnerable CYSHCN and their families. The primary tasks of DFD include directing NJ's welfare program, Workfirst NJ (WFNJ), and providing funding, information management services, and administrative support to the county and/or municipal welfare departments that implement the federally funded Food Stamps food assistance program. The DFD also oversees child care licensing, Kinship supports for families, and child support. The federal SSI benefit program for aged, blind or disabled individuals is also supplemented by DFD. WFNJ recipients who may be eligible for federal SSI benefits can now get free legal help. The DFD has established an agreement with Legal Services of New Jersey (LSNJ) to assist recipients in either filing for SSI benefits or appealing a denial of benefits. The DHS Division of Disabilities Services (DDS) and SCHEIS collaborate to promote and facilitate independence and participation for people with disabilities in all aspects of community life. Through its system of Information and Referral (I&R), the DDS supports active information exchange regarding community services and fosters coordination and cooperation among government and community-based agencies. The I&R Specialists commonly refer families of CYSHCN to the SCHEIS CECs, Tertiary Care Centers and Cleft Lip/Palate and Craniofacial Anomalies Centers; SCHS CM and family supports. In addition, SCHEIS refers families to the Traumatic Brain Injury (TBI) Fund, TBI Waiver and Personal Preference: NJ Cash and Counseling Program; and the Medicaid Personal Care Assistant (PCA) services. The SCHEIS regularly uses these DDS resources to assist families of CYSHCN to find health and transition to adulthood supports. In addition, the SCHS CMUs are the contracted case management vendors for the AIDS Community Care Alternatives Program (ACCAP) waiver; and Community Resources for People with Disabilities (CRPD) waiver. Currently, SCHEIS State staffs serve on a DDS committee charged with developing a standardized waiver application.

Statewide mental health services for CYSHCN with serious and persistent mental illnesses are coordinated by the DHS Division of Mental Health Services (DMHS) and the Division of Addiction Services (DAS). Supporting CYSHCN with emotional/behavioral co-morbidities and their families is a challenge. The SCHEIS' CECs, FASD's, and Tertiary Care Centers serve as a vital community-based asset for families and mental health providers to consult for comprehensive evaluations and treatment of CYSHCN. Likewise, the SCHS CMU's link CYSHCN with emotional behavioral needs to the mental health and specialized pediatric providers to coordinate access to care across those systems.

Agencies operating in but not of DHS include Boards, Councils, Commissions, and Committees. They are organized to target specific special needs populations and provide opportunities for policy development, advocacy, and services. The agencies with which the Department and/or SCHEIS share common populations and collaborate with to better serve CYSHCN follows below.

In operation for over 20 years, the Catastrophic Illness in Children Relief Fund (CICRF) Commission administers a financial assistance program for NJ families whose children have an illness or condition otherwise not fully covered by insurance, State or Federal programs, or other source, such as fundraising. An income to debt ratio is applied to determine the measure of medical debt incurred by the applicant family. By legislative mandate, the Division of Family Health Services (FHS) sits on the CICRF Commission. The FHS maintains a memorandum of agreement with the CICRF program to formally refer children birth to 21 years of age whose families have accumulated medical debt for the care and treatment of their children's medical condition. All applications received by the State CICRF program are forwarded to the SCHS CMU in the CYSHCN's county of residence for intake, information and referral, individualized service plan development, intermittent monitoring of needs, and registration with the BDARS.

The NJ Council on Developmental Disabilities (NJ CDD) functions in accordance with the federal Developmental Disabilities Assistance and Bill of Rights Act, and in New Jersey State government by N.J.S.A. 30:1AA 1.2 and is codified in Title 10 of the State Administrative Codes. According to State statute the Title V agency has a seat on the NJ CDD, other State agencies, persons with DD, and/or family members comprise the balance of the Council. The purpose of

the NJ CDD is to engage in advocacy, capacity building, and systemic change that contribute to a coordinated, consumer and family-centered, consumer and family-directed comprehensive system that includes needed community services, individualized supports, and other forms of assistance that promote self determination for individuals with developmental disabilities and their families. Title V serves in this capacity by collaborating on the development and implementation of the Council's State Plan, participating in policy development, contributing to program development targeting persons with DD across the lifespan, and facilitating the competitive grant process to implement programs on a local level.

The Medical Assistance Advisory Committee (MAAC) operates pursuant to 42:CFR446.10 of the Social Security Act. The 15 member Committee is comprised of governmental, advocacy, and family representatives and is responsible for analyzing and developing programs of medical care and coordination. State SCHEIS staffs participate at MAAC meetings and share information on access to care through Medicaid managed care with Committee members as well as with SCHEIS programs. Likewise, information shared by the MAAC is incorporated into SCHEIS program planning to better assure coordination of resources, services, and supports for CYSHCN across systems.

The Department of Education is responsible for overseeing more than 600 school districts, and administering education programs to more than 1.4 million public and nonpublic elementary and secondary school children. The Office of Special Education Programs, within the Division of Student Services, has oversight responsibilities for the provision of education and related support services to students with disabilities, aged 3 to 21. In addition to local level collaboration and child find between school districts and the SCHEIS programs and services; i.e., child study team referral to CEC's for comprehensive evaluations, pre-school handicapped transition planning conducted by Early Intervention Services (EIS) and SCHS CM, and collaboration between school nurses and SCHS CM, the State DOE and DHSS Title V programs serve on committees, collaborate on policy and implement programs.

The Department of Banking and Insurance (DOBI), Division of Insurance, is comprised of units which are charged with the licensing and oversight of the various types of insurance regulated by the State of New Jersey. The Division of Insurance issues licenses to insurance companies, producers, and other risk-assuming entities, reviews insurance products and rates for compliance with existing regulations, and monitors the financial solvency of licensees to ensure product availability in the marketplace. The Division also responds to consumer concerns and inquiries and endeavors to educate consumers regarding insurance products and issues. In order to ensure access to health insurance and benefits to enrolled CYSHCN, SCHEIS collaborates with DOBI colleagues in the development of policy and procedure; i.e., Grace's Law, EIS, and Autism. Likewise, DOBI partners participate with SCHEIS in provider and consumer education and advocacy and regularly provide technical assistance and training at the SCHS quarterly meetings. State SCHEIS staffs are dialoguing with DOBI staff in planning for NJ implementation of the Patient Protection and Affordable Care Act (PPACA).

The Department of Children and Families (DCF) is focused on strengthening families and achieving safety, well-being, and permanency for all New Jersey's children. Current priorities focus on child welfare, safety, health, family strengthening, and the establishment of foster homes. DCF is also engaged in reengineering child abuse prevention, building capacity in the child behavioral health system, and improving the system of health care for children in the State's care. Collaboration between State SCHEIS, local agencies implementing CYSHCN health and related support services, and the statewide DCF system are ongoing to ensure access to health and related services to the most vulnerable CYSHCN.

Linkages with the DCF's Division of Prevention and Community Partnerships, Division of Community Services, and Office of Education ensures access to behavioral health providers, emergency response providers, the DCF child health nurses, and local child protection services offices. These linkages are essential for SCHS Case Managers, Specialized Pediatric Services (SPS) provider agencies, Ryan White Part D (RWPD) providers, EIS, and other DHSS programs



to maintain capacity to serve the State's most vulnerable children.

Collaboration with the Department of Labor and Workforce Development ensures access to programs such as Vocational Rehabilitation, Social Security Disability Determination, Temporary Disability Insurance, and Workers Compensation.

## F. Health Systems Capacity Indicators

### Introduction

Health Systems Capacity Indicators are presented individually with multi-year data.

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	47.7	50.2	49.2	43.5	43.5
Numerator	2687	2801	2741	2424	2424
Denominator	563900	557980	556673	557421	557421
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

### Notes - 2009

2008 data entered as estimate for 2009.

Final 2009 data will be available in 2011.

### Notes - 2008

Denominator of 2008 from Population Division, US Census Bureau,  
<http://www.census.gov/popest/states/asrh/tables/SC-EST2008-01.xls>

Final 2008 data will be available in 2011.

***An attachment is included in this section.***

### Narrative:

Asthma is the most common chronic disease reported in children. It is a leading cause of hospital stays and school absences and poses significant limitations on quality of life for many children and families. Asthma prevalence has increased worldwide in recent years. This trend has been linked to environmental factors, including air pollution. However, it is important to understand that indoor triggers can play just as much of a role as outdoor triggers in bringing on an asthma attack. The importance of access to consistent, quality health care cannot be overlooked in the attempt to reduce the burden of pediatric asthma. The rate of pediatric asthma hospitalizations appears to be decreasing in recent years most likely due to improvements in the chronic care management of children with asthma.

The DHSS Asthma Awareness and Education Program (AAEP) funds the American Lung Association of MidAtlantic (ALAMid), to support the infrastructure of the Pediatric/Adult Asthma Coalition of New Jersey. The PACNJ implements strategies and initiatives to address the asthma

burden, and assist the Department in implementing the State Asthma Strategic Plan. With over 70 members on six task forces, PACNJ works with schools, child care providers, health care providers, health insurers, community groups and environmental agencies to reach all individuals in New Jersey with the most effective methods for managing their asthma. PACNJ maintains 6 task forces including: Quality, Community, Schools, Child Care, Environment, and Evaluation. The 6 task forces are an integral component to PACNJ's success. The task forces meet to identify, review and design the various objectives and interventions. With the support of staff and resources from PACNJ and its member organizations, the task forces design and implement the various strategies/activities identified in the implementation plan.

The Asthma Coordinator and Epidemiologist for FHS serves on the PACNJ Coordinating Committee. Other state staff, particularly those on the State Asthma Committee, attend PACNJ meetings and participate in activities. The AAEP staff serves as liaison to facilitate collaborations with various internal and external stakeholders to ensure the implementation and accomplishment of PACNJ's initiatives.

The attached Table PACNJ Highlights lists recent PACNJ accomplishments.

The AAEP has collaborated with the NJDHSS Office of Minority and Multicultural Health (OMMH) in funding three community-based organizations to implement the Community Health Mobilization Grant Reducing Pediatric Asthma Disparities in Camden, Trenton and Newark. The project focus is to reduce pediatric emergency department visits and school absences for asthma in minority communities by reducing exposure to asthma triggers and by improving ability to self-manage asthma symptoms, through: 1) collaboration, 2) outreach, 3) identification and linkage 4) case management, 5) education and 6) evaluation.

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Indicator	94.7	0.0	90.5	92.0	100.0
Numerator	35668	0	36166	36639	43135
Denominator	37646	56371	39971	39805	43135
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2009**

Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 4/2/2010.

**Notes - 2008**

Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 4/2/2009.

**Narrative:**

Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive preventive child health services to all Medicaid eligible children under age 21 including periodic physical, hearing, vision and developmental screenings. Identifying physical and developmental issues through screening of infants can significantly affect early child development and school readiness.

Medicaid in NJ is administered by the Division of Medical Assistance and Health Services (DMAHS) in the NJ Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in Medicaid. The performance on this indicator has improved greatly and according to the 2009 Annual EPSDT Participation Report (Form CMS-416), all infants enrolled in Medicaid receive at least one periodic screening. This high performance on the indicator is supported by the large increase in the total number of screens received by infants (151,834 during 2009) also reported on the 2009 Annual EPSDT Participation Report.

One of the major focuses of the Childhood Lead Poisoning Prevention Projects (CLPPP) is to promote proper use of preventive health services by the families of children who are lead burdened and at high risk of preventable health and developmental problems. CLPPP nurse case managers work with the parents of these children to encourage their enrollment in Medicaid or NJ FamilyCare (if eligible), and the use of preventive and primary care pediatric services, particularly immunization and lead screening. There are CLPPPs in 12 communities.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Indicator	0.0	0.0	90.5	92.0	100.0
Numerator	0	0	36166	36639	43135
Denominator	1	1	39971	39805	43135
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2009**

Data for HSCI #3 is currently not available. An estimate of the indicator using the percentage of periodic screenings for all New Jersey FamilyCare enrollees under age 1 is available from the Annual EPSDT Participant Report.

**Notes - 2008**

Data for HSCI #3 is currently not available. An estimate of the indicator using the percentage of periodic screenings for all New Jersey FamilyCare enrollees under age 1 is available from the Annual EPSDT Participant Report. The estimate for 2008 is  $36,639 / 39,805 = 92\%$ .

**Narrative:**

New Jersey FamilyCare is New Jersey's SCHIP. The Division of Medical Assistance and Health Services (DMAHS) in the NJ Department of Human Services (DHS) administers NJ FamilyCare and the Medicaid Program. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in NJ FamilyCare. Data for this indicator have been requested from DMAHS, but are not available. Data for Medicaid enrolled infants is provided as an estimate considering that the same Medicaid HMO plans cover SCHIP enrolled infants with the same benefit package.

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	65.3	65.0	65.8	64.8	66.0
Numerator	72085	72675	72506	70714	70633
Denominator	110364	111727	110168	109198	106944
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2009**

Source provisional 2009 Electronic Birth Certificate file.

HSCI #04 - 2009 provisional data is for percent of NEWBORNS

Final 2009 data will be available in 2011.

**Notes - 2008**

Source: 2008 Electronic Birth Certificate file.

HSCI #04 - 2008 provisional data is for percent of NEWBORNS

**Narrative:**

Improving access to prenatal care is essential to promoting the health of NJ mothers, infants, and families. Early and adequate prenatal care is an important component for a healthy pregnancy because it offers the best opportunity for risk assessment, health education, and the management of pregnancy related complications and conditions. HSCI #4 measures the percent of mothers who have received appropriate prenatal care as measured by the Kotelchuck Index.

Many factors delay the initiation of early prenatal care, including unintended pregnancies, lack of awareness of a pregnancy and lack of insurance. Despite major expansions of health care access during the 1990s, one in five women giving birth in NJ in 2008 still failed to receive first trimester prenatal care. Mothers most likely to benefit from early prenatal care because of their higher risk of poor birth outcomes remain even less likely to receive it. Efforts to improve access to early prenatal care must also focus on women before they become pregnant through the promotion of preconception care and family planning services.

In February 2008 a Commissioner's Prenatal Care Task Force was convened to make

recommendations to improve access to prenatal care in New Jersey. The Task Force was comprised of physicians, nurses, administrators and others with expertise in maternal and child health. The Task Force presented a report and recommendations to Commissioner Howard in July 2008. Commissioner Howard launched a public awareness campaign statewide using a variety of venues including Healthy Mothers, Healthy Babies, MCH Consortia, hospitals, federally qualified health centers, colleges and others. A request for applications for the Access to Prenatal Care Initiative was developed to implement recommendations contained in the Commissioner's Prenatal Care Task Force Report.

The goal of the Access to Prenatal Care Initiative is to increase the rate of first trimester prenatal care in NJ to at least 90% to coincide with the National Healthy People 2010 goal, with emphasis on racial and ethnic disparities. Related goals include decreasing the rate of preterm births and low birth weight newborns and reducing infant mortality. Education of providers and consumers, linkages of women and their partners to a medical home, and increased availability of services for prenatal, preconception and interconception are additional goals of the initiative. Projects seeking funding should be able to produce measurable positive outcomes in increasing the number of women accessing early prenatal care and or increasing access for reproductive age women and their partner for preconception and interconception care. Nine projects were funded a variety of best practice models. The individual projects are described in Section IV.C. NPM #18.

**Health Systems Capacity Indicator 07A:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Indicator	57.7	59.4	61.8	56.0	59.0
Numerator	290478	317312	335797	338979	378982
Denominator	503008	534469	542985	605041	642519
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2009**

Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 4/2/2010.

Numerator reports eligibles (0-21 yrs) receiving at least one initial or periodic screen which is an under estimation of Medicaid eligibles receiving a service paid by the Medicaid Program.

**Notes - 2008**

Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 4/2/2009.

Numerator reports eligibles (0-21 yrs) receiving at least one initial or periodic screen which is an under estimation of Medicaid eligibles receiving a service paid by the Medicaid Program.

**Narrative:**

The need for health insurance among children in NJ is great and may be growing as a result of the current economic downturn. Providing services to all potentially Medicaid-eligible children is a challenge that requires the timely identification of uninsured children and will require the collaborative efforts of multiple state departments.

Many families are not aware of the availability of free or low cost health insurance programs. Others are overwhelmed by the requirements and information necessary for the enrollment and renewal processes or are unable to pay required monthly premiums and either never enroll or drop off the rolls each month despite being eligible for Medicaid or NJ FamilyCare. Many reasons are cited as barriers to enrollment and retention including: language barriers, concerns regarding immigration status, financial hardships, mistrust of government programs and inability to meet documentation requirements.

The NJ Health Care Reform Act of 2008 directed the Commissioner of the Department of Human Services (DHS) to establish the Outreach, Enrollment, and Retention Work Group (Work Group) to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare or NJ FamilyCare ADVANTAGE, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs.

Recent changes in federal law give states new opportunities to streamline procedures for enrolling children in health insurance programs and improving the efficiency and effectiveness of enrollment and retention practices. NJ is the first state to take advantage of these new opportunities and is in the midst of executing an unprecedented direct outreach campaign. NJ developed an Express application for enrolling children in NJ FamilyCare and Medicaid and is mailing it to the households of the nearly 360,000 children who were identified as uninsured on state tax returns.

Based on the Work Group's research and discussion, barriers and recommendations were identified. A report, NJ FamilyCare Outreach, Enrollment and Retention Report May 2009, was produced which identifies findings and recommendations to help meet goals of the Reform Act.

Despite the fact that all relevant departments are willing to work cooperatively to achieve the goal, additional work is needed to coordinate and implement various activities. A thoughtful planning process among all government entities serving children and families is needed, in concert with technological improvements that will create a streamlined and coordinated assistance program infrastructure. An inclusive planning process to determine which technological improvements are necessary across departmental data systems is in place and moving forward. Federal health insurance reforms and expansion of Medicaid and SCHIP will also positively impact children and families in need of health care services.

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Indicator	33.3	39.9	43.7	44.6	51.8
Numerator	36065	41222	51042	53714	66437
Denominator	108419	103251	116822	120383	128294
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

#### **Notes - 2009**

Source: Form CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services  
2009 report dated 4/2/2010.

#### **Notes - 2008**

Source: Form CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services  
2008 report dated 4/2/2009.

#### **Narrative:**

Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive preventive child health services to all Medicaid eligible children under age 21 including periodic physical exams; hearing, vision and developmental screenings; lead poisoning screening; vaccines; health education; and dental inspections and referrals. Medicaid in NJ is administered by the Division of Medical Assistance and Health Services (DMAHS) in the NJ Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in Medicaid. The performance on this indicator has improved greatly and according to the 2009 Annual EPSDT Participation Report. A total of 66,437 (51.8%) eligible children ages 6 to 9 years old received dental services during 2009 out of 128,294 children eligible for EPSDT services. Dental initiatives undertaken to promote utilization of dental services include:

**Oral Health Stuffer:** The stuffer notes, "Healthy Oral Habits", is a summary of dental treatment benefits available from the program in English and Spanish. It is included in a letter to families advising them that an initial visit is needed. It is also included in a letter that indicates the child has not been seen in 6 months and an appointment should be made. In addition, the stuffer is posted on the Department of Human Services (DHS) website.

**Quarterly Medical and Dental Director Meetings:** In moving towards an integrated medical dental model of care, the Office of Quality Assurance now conducts a joint HMO medical dental directors quarterly meeting where all aspects of care including EPSDT are discussed.

**Periodicity of Dental Services for Children in New Jersey Family Care (NJFC)/Medicaid:** A chart is available on the DHS website to show dental services available for children in the NJFC program. The chart includes the age for when the service can be provided and additional notes for services to children with special health care needs. It recommends a dental visit should occur as early as the eruption of the first tooth and is required by age 3. The chart is available in English and Spanish.

**Age of Comprehensive Evaluation:** A contract change with the NJFC HMOs effective July 1, 2010 notes that the service should be provided as early as the eruption of the first tooth and is required by age 3. Providers are advised through the Division Newsletter and through their HMOs.

**Dental Benefits Flyer:** An educational flyer noting the program's dental benefits is distributed at the County Welfare and Medical Assistance Customer Centers.

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Indicator	60.0	60.0	58.4	59.7	53.2
Numerator	4800	4500	4500	4600	7348
Denominator	8000	7500	7700	7700	13810
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2009**

Estimated by SCHEIS from monthly SSI reports. In 2009 computerized access to the monthly SSI reports report actual unduplicated data.

**Notes - 2008**

Estimated by SCHEIS from monthly SSI reports.

**Narrative:**

In accordance with the charge to ensure that Supplemental Security Income (SSI) beneficiaries less than 16 years old receive rehabilitation services, SCHEIS links each CYSHCN referred by the Social Security Administration to their SCHS Case Management Unit for follow-up. From point of referral, outreach is conducted by a county SCHS Case Manager (registered nurse/social worker). Intake is offered and provided accordingly. Needs are identified with the parent/guardian. The case manager provides information on local, State and/or federal resources including referral to rehabilitative services, pediatric specialty, medical home, family support and other services as needed. For example, clinical services may be provided through the Specialized Pediatric Services providers; Child Evaluation Centers, Cleft Lip/Palate Centers and Tertiary Care Centers, and/or family support. With family input the SCHS Case manager develops an individualized service plan (ISP) based on the child's needs. Goals are determined with the parent/guardian, monitoring dates are planned, follow-up is conducted and outcomes are measured. Assistance to linkage with services is offered and provided as needed.

In 2009, the monthly SSI report was revised from a paper report to a web based format and it is accessed online through the NJ State portal. County specific reports of active, terminated and expired status are password protected and viewable only to State staffs and the SCHS Case Management Units in the county in which the child resides. The efficiency of shifting to electronic reporting and referral afforded SCHEIS more accurate reporting; 13,810 CYSHCN referred in 2009 versus 7,700 in 2008 (44% increase in total unduplicated referrals); and 7,348 CYSHCN served in 2009 versus 4,600 in 2008, (60% increase in unduplicated served). In 2009, 22% (2,350) of the 10,500 active children (with ISP's) served statewide through the County Case Management Units were identified as SSI beneficiaries.

**Health Systems Capacity Indicator 05A:** *Percent of low birth weight (< 2,500 grams)*

<b>INDICATOR #05</b>	<b>YEAR</b>	<b>DATA SOURCE</b>	<b>POPULATION</b>
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<b>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</b>			<b>MEDICAID</b>	<b>NON-MEDICAID</b>	<b>ALL</b>
Percent of low birth weight (< 2,500 grams)	2005	matching data files	8.7	7.9	8.4

**Narrative:**

Low birthweight (LBW) is an important measure of a healthy birth outcome and is a major risk factor for future health conditions, disability, and death. Disparities in LBW are largely driven by persistent racial/ethnic and socio-economic disparities in LBW. Nationally the percentage of infants born LBW has increased for more than two decades. Factors that have contributed to this increase are: the increases in multiple births, which are more likely to result in LBW infants than singleton births (though singleton LBW has also increased); obstetric interventions such as induction of labor and cesarean delivery; infertility therapies; and delayed childbearing.

Based on the recommendations from the Prenatal Care Task Force, funding was redirected to the Access to Prenatal Care Initiative to decrease the rate of LBW, preterm births and infant mortality and to increase access to prenatal care. Infant mortality reduction funding was redirected from Healthy Mothers, Healthy Babies Coalition outreach and education to the Access to Prenatal Care Initiative request for applications. The Access to Prenatal Care Initiative in addition to FIMR, Perinatal Addictions Prevention, Postpartum Mood Disorders initiatives are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. HM,HB Coalitions are designed to improve early prenatal care utilization (NPM #18) and birth outcomes through extensive community outreach and education activities based on Community Action Team projects based on FIMR results. The Fetal Alcohol Spectrum Disorders and Perinatal Addictions Prevention Projects (SP #9) educate providers and consumers on the effects of substance use and abuse on LBW, infant mortality and prenatal care. Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. The hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period.

**Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births***

<b>INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</b>	<b>YEAR</b>	<b>DATA SOURCE</b>	<b>POPULATION</b>		
			<b>MEDICAID</b>	<b>NON-MEDICAID</b>	<b>ALL</b>
Infant deaths per 1,000 live births	2005	matching data files	7.6	6.5	6.7

**Narrative:**

Multiple factors contribute to the disparity in infant death rates between the Medicaid and non-Medicaid population. Preconceptual women's health, access to family planning services, access to early prenatal care, maternal medical risk factors, social and behavioral risk factors all contribute to the persistent disparities in infant mortality rates. The Prenatal Care Task Force Report contained recommendations for consideration and possible implementation to improve

prenatal care and reduce infant mortality. The recommendations stressed many important goals such as increasing public awareness of preconception health, ensuring the availability of ongoing early prenatal care services, and promoting equity in birth outcomes. The Department through Reproductive and Perinatal Health Services issued a competitive request for application to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates, called the Access to Prenatal Care Initiative. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care.

The Access to Prenatal Care Initiative, FIMR, FASD, Perinatal Addictions, Post Partum Depression Initiative are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. The BIMR Center is designated to reduce BIM (SP#3) through public awareness, community education, professional education and the provision of direct health service grants. MCHC conducts community outreach and education activities based on Community Action Team projects based on FIMR results. The FASD and Perinatal Addictions projects (SP #1) educate providers and consumers on the effects of substance use and abuse on LBW, infant mortality and prenatal care. Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. The hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period.

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	matching data files	59.2	84.5	75.1

**Notes - 2011**

Data is from a file created by the MCH Epidemiology Program by matching the Electronic Birth Certificate file to the official Birth Certificate file. Most recent year available is 2005. Calculated rates/percents may not match rates/percents from the official Birth Certificate files due to missing and unknown insurance type.

**Narrative:**

Improving access to first trimester prenatal care is essential to promoting the health of New Jersey mothers, infants, and families. Early prenatal care is an important component for a healthy pregnancy because it offers the best opportunity for risk assessment, health education, and the management of pregnancy related complications and conditions. Access to prenatal care is extremely important; yet many factors delay the initiation of early prenatal care, including unintended pregnancies, lack of awareness of a pregnancy and lack of insurance.

According to New Jersey PRAMS survey data cited in the Commissioner's Prenatal Care Task Force Report, maternal demographics such as age, education and marital status affected first

trimester prenatal care rates, but health insurance status during pregnancy had the stronger effect on first trimester prenatal care rates. Mothers who were privately insured were most likely to enter first trimester prenatal care for all age, education or marital status groups. Chances of first trimester prenatal care increased when the mothers were married, had at least a high school education and were at least 20-29 years old.

Mothers with continuous FamilyCare coverage, meaning they had FamilyCare coverage both before and during the pregnancy, had a first trimester prenatal care rate of 78%. New FamilyCare mothers, which include those who enrolled in FamilyCare during their pregnancy, had a first trimester prenatal care rate of 76%. Mothers with No Insurance during prenatal care had the lowest rate of first trimester prenatal care at 73%. Before pregnancy 21% of mothers, including 54% of FamilyCare mothers, had no health insurance and most likely lacked ongoing preventive health care before pregnancy.

Efforts to improve access to early prenatal care must address the factors related to unintended pregnancy and lack of early pregnancy awareness by focusing on women before they become pregnant. Preconception care is a critical component of prenatal care and health care for all women of reproductive age. The main goal of preconception care is to provide health promotion, screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Given the relationship between pregnancy intention and early initiation of prenatal care, assisting women in having a healthy and planned pregnancy can reduce the incidence of late prenatal care. Policies to promote family planning are a priority not only because they reduce unintended pregnancies, but also because they can improve the initiation of early prenatal care.

The Prenatal Care Task Force Final report contained recommendations to improve first trimester prenatal care. The recommendations of the Task Force and the implementation of the Access to Prenatal Care Initiative by Reproductive and Perinatal Health Services has been described in the earlier sections on HSCI #4, 5A and 5B.

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2005	matching data files	45.9	71	62.2

**Notes - 2011**

Data is from a file created by the MCH Epidemiology Program by matching the Electronic Birth Certificate file to the official Birth Certificate file. Most recent year available is 2005. Calculated rates/percents may not match rates/percents from the official Birth Certificate files due to missing and unknown insurance type.

**Narrative:**

Adequate as well as early prenatal care is important in helping to prevent poor birth outcomes such as preterm labor and birth, low birth weight and infant mortality. In addition to improving maternal health and birth outcomes, early and adequate prenatal care promotes preventive care for young children. The disparity in access to early and adequate prenatal care has been a focus for FHS. The Prenatal Care Task Force report contained specific recommendations addressing issues related to Medicaid coverage and barriers to women initiating early prenatal care, especially in areas affected by hospital closures or reductions in obstetric services. Efforts to address disparities in prenatal care utilization by FHS through the Access to Prenatal Care Initiative have been described in earlier sections on HSCI #4, 5A, 5B and 5C.

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Infants (0 to 1)	2009	185
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Infants (0 to 1)	2009	350

**Narrative:**

The Medicaid Program in New Jersey is located in the Division of Medical Assistance and Health Services (DMAHS) in the Department of Human Services. DMAHS also administers the SCHIP program. Pregnant women with incomes below 185% of the Federal Poverty Level are eligible for Medicaid maternity services. A child born to a woman eligible for and receiving Medicaid is guaranteed eligibility for one year. The comprehensive services include medical care, case coordination, health education and psychological services. Income eligibility levels for NJ FamilyCare by child age and family size are available at <http://www.njfamilycare.org/pages/whatItCosts.html>

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Medicaid Children (Age range 1 to 18) (Age range to ) (Age range to )	2009	185
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 1 to 18) (Age range to ) (Age range to )	2009	350

**Narrative:**

The Medicaid Program and SCHIP Program in New Jersey are located in the Department of Human Services. Pregnant women and children with incomes below 185% of the Federal Poverty Level are eligible for Medicaid. The comprehensive services include medical care, case coordination, health education and psychological services.

The percent of poverty level for eligibility in the SCHIP Program for infants and children 1 to 18 is 350%. Income eligibility levels for NJ FamilyCare by child age and family size are available at <http://www.njfamilycare.org/pages/whatItCosts.html>.

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Pregnant Women	2009	200
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women	2009	350

**Narrative:**

The Medicaid Program and SCHIP Program in New Jersey are located in the Department of Human Services. Pregnant women with incomes below 200% of the Federal Poverty Level are eligible for Medicaid. The comprehensive services include medical care, case coordination, health education and psychological services.

The percent of poverty level for eligibility in the SCHIP Program for pregnant women is 350%. Income eligibility levels for NJ FamilyCare by child age and family size are available at <http://www.njfamilycare.org/pages/whatItCosts.html>.

Several initiatives including Healthy Mothers/Healthy Babies and Healthy Start promote the early enrollment and full participation in the Medicaid and SCHIP Programs.

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid	2	No

Eligibility or Paid Claims Files		
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

#### **Notes - 2011**

#### **Narrative:**

The goals of the State Systems Development Initiative (SSDI) grant within the MCH Epidemiology Program focus on for building data capacity in MCH (Health Status Indicator (CHSI) #9A). The goals of the grant are improving linkages of MCH datasets and improving access to MCH related information. Linking MCH related datasets is important to the needs assessment process for communities and the evaluation of program services. Assuring access of FHS to MCH related datasets is important to improving the reporting of Title V MCH Block Grant Performance/Outcome Measures and to improving the delivery of services to the MCH population. Examples of efforts to utilize MCH data include the Commissioner's Prenatal Care Task Force and the Population Perinatal Risk Index.

Our vital statistics files, Medicaid files and programmatic data files all provide some information about the status of health in the MCH population and the effectiveness of MCH programs. However, no file alone provides the full picture of what happens to pregnant women, infants and children. In order to accurately assess the continuum of events that lead to favorable or unfavorable outcomes, files and information systems must be linked.

The MCH Epi Program has been able to both link records across files and longitudinally across health care related events in a mother's life. A combined dataset was created for the years 1996 through 2006 containing the electronic birth certificate, mother and newborn hospital discharge records, and infant death certificates for all NJ births. Data from this dataset are used to support research projects that focus on welfare reform and immigrant health, foreign-born mothers and issues related to health disparities, and maternal mortality review in New Jersey.

Asthma-related hospital discharge data have been longitudinally linked to create a wealth of information surrounding hospitalizations for children with asthma. This dataset is being used to enhance our asthma surveillance system as well as examine issues related to repeat admissions, and asthma severity.

The MCH Epidemiology Program with CDC funding has also implemented the Pregnancy Risk Assessment Monitoring System (PRAMS) Survey in collaboration with the Bloustein Center for Survey Research at Rutgers University. Data from this survey will be used to identify high-risk

pregnancy groups and to target programmatic interventions. Information from PRAMS is used to help plan better health programs for New Jersey mothers and infants. NJ PRAMS briefs on a variety of topics are available at the NJ PRAMS website - <http://nj.gov/health/fhs/professional/prams.shtml>

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
New Jersey Youth Tobacco Survey	3	No

**Notes - 2011**

**Narrative:**

Adolescent smoking and smokeless tobacco use are the first steps in a preventable public health tragedy. Adolescent users become adult users, and few people begin to use tobacco after age 18. Preventing young people from starting to use tobacco is the key to reducing the death and disease caused by tobacco use. Access to accurate information on information concerning youth tobacco use is critical to addressing the epidemic of tobacco use in the United States. The smoking rate among NJ high school students declined sharply during 1997--2003; however, rates have remained relatively stable over the past several years. According to the 2009 high school YRBS survey (NJ Student Health Survey), 17 percent of high school students reported cigarette use during the previous month and 4% reported being daily smokers.

The New Jersey Youth Tobacco Survey (YTS), based on a model developed by CDC, is administered by the Comprehensive Tobacco Control Program within FHS. This bi-annual survey is administered to a sample of students in grades seven through twelve.

An effective strategy to reduce youth smoking prevalence and consumption is to increase the unit price for tobacco by raising the product's excise tax. According to a report from the NJDHSS Comprehensive Tobacco Control Program ([http://www.state.nj.us/health/as/ctcp/documents/youth\\_consumption\\_of\\_cigarettes.pdf](http://www.state.nj.us/health/as/ctcp/documents/youth_consumption_of_cigarettes.pdf)), the overall decline in youth cigarette consumption in New Jersey reflects, in part, the effects of large increases in the State's cigarette excise tax. New Jersey increased the cigarette excise tax four times in as many years and currently ranks as one of the highest cigarette excise tax among all US states. Higher cigarette taxes generally reduce smoking prevalence and consumption, while increasing tax revenue.

In addition to price increases, several strategies can achieve a substantial reduction in youth consumption. These include limiting youth access to tobacco, strong community-based programs concentrating on secondhand smoke, mass media campaigns combined with community-wide interventions, and evidence-based school health programs.

However, initiatives to reduce youth smoking must be maintained and accompanied by changes in adult behavior. Policy makers must consider approaches that sustain delayed initiation into adulthood. Comprehensive, effective, and sustainable tobacco-control programs, as well as tobacco cessation programs, are essential to reduce tobacco caused disease, death and disability.

Finally, consistent funding for youth prevention must continue. Despite the considerable success

achieved in New Jersey, funding for comprehensive tobacco control continues to be reduced. There is evidence that higher state-level tobacco control funding is associated with lower youth smoking prevalence and cigarette consumption.



## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations.

Since 1999 Maternal Child Health Bureau (MCHB) has included performance plans and performance information in its budget submission. MCHB must submit annual reports to Congress on the actual performance achieved compared to that proposed in the performance plan. This section describes the performance reporting requirements of the Federal-State partnership. Figure 3, "Title V Block Grant Performance Measurement System" on page 45 of the federal guidance, presents a schematic of a system approach that begins with the needs assessment and identification of priorities and culminates in improved outcomes for the Title V population. After each State establishes a set of priority needs from the five-year statewide needs assessment, programs are designed, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH "pyramid" -- direct health care, enabling, population-based, and infrastructure building services. Program activities, as measured by 18 National performance measures and State performance measures should have a collective contributory effect to positively impact a set of 6 national outcome measures for the Title V population.

***An attachment is included in this section.***

### **B. State Priorities**

This section describes the relationship of the priority needs, the National and State performance measures, and the capacity and resource capacity of the State Title V program.

#### **SP #1. Increasing Healthy Births**

Increasing Healthy Births is a state priority that encompasses reducing low birth weight, preterm births, infant mortality, and increasing first trimester prenatal care and adequate prenatal care (NPM #8, 15, 17, 18). Several initiatives address healthy births including Healthy Mothers, Healthy Babies Coalition outreach activities, Healthy Start outreach activities, Community Action Team projects based on FIMR findings, and most recently the Access to Prenatal Care Initiative. The Perinatal Addictions Prevention projects seek to educate professionals and consumers of the risks involved with substance use and abuse in the perinatal period. Preconceptual health projects seek to have a healthy mother prior to conception.

The Family Planning projects provide a broad range of acceptable and effective family planning methods and related preventive health services that include natural family planning methods, infertility services and services for adolescents. Clinics have effective contraceptive methods, breast and cervical cancer screening, nutrition and prevention services that correspond with nationally recognized standards of care, sexually transmitted infections (STIs) and HIV prevention education, testing and referral, adolescent abstinence counseling, and other preventive health services. Aimed at schools and community groups, educational activities focus on primary pregnancy prevention, the program integrates assessment of adolescent risk behavior within routine family planning services. Reduction in the number of clinic sites may begin in January due to the loss of State funding. The Family Planning agencies are exploring options for changes in the delivery system based on the reduction of funds.

The Family Planning Program hosts an annual Adolescent Health Institute to bring together

adolescent stakeholders from throughout NJ to foster networking and collaboration and to provide an opportunity to focus on new information and resources as they pertain to the many issues facing adolescents. The 11th annual Adolescent Health Institute will be held on November 13, 2010.

A public awareness campaign was launched statewide using a variety of venues including Healthy Mothers, Healthy Babies, MCH Consortia, hospitals, federally qualified health centers, colleges and others. A request for applications was developed to implement recommendations contained in the Commissioner's Prenatal Care Task Force Report issued in July 2008. This competitive request for applications seeks to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates.

#### SP #2. Improving Nutrition and Physical Activity

Improving Nutrition and Physical Activity is a state priority related to SPM # 5 and NPM #14 and the growing obesity epidemic in NJ and nationally. NJ has one of the highest obesity rates among low-income children 2 to 5 years of age at nearly 18 percent in 2008. The obesity epidemic is taking a toll on the future health of our children by contributing to the rise in related chronic diseases and disabilities, and adding billions of additional dollars in health care costs. Children who are obese are at grave risk of lifelong, chronic health problems like heart disease, asthma, arthritis and cancer.

In 1999, State law established the NJ Council on Fitness and Sports (NJCFS), which is in, but not of, the DHSS. The NJCFS promotes the health and wellness of NJ citizens by developing safe and enjoyable recreational and sports activities and programs. The NJCFS continues to fund mini grants to promote health and physical activity in communities. In 2004 the NJ Obesity Prevention Task Force was created to promote obesity prevention among NJ residents, especially among children and adolescents.

In May 2008 DHSS was awarded a 5-year cooperative agreement by the CDC to the Office of Nutrition and Fitness (ONF) to provide state leadership and coordination of nutrition, physical activity and obesity (NPAO) strategies. Through this cooperative agreement ONF has taken the lead in building a robust infrastructure by creating a statewide partnership of organizations and individuals, called ShapingNJ, to collaborate, build capacity and develop a comprehensive and coordinated system to halt further increases in obesity and other chronic diseases. Activities of the ONF and the ShapingNJ partnership are discussed in detail in the section on NPM #14 and SPM #4.

#### SP #3. Reducing Black Infant Mortality

Maternal and Child Health Services (MCHS) has a long history of interest in perinatal health disparities with special emphasis in 1985 when the Infant Mortality Reduction Initiative was initiated. Subsequently, MCHS submitted an application for the initial round of Healthy Start projects. In 1996, the Department established the Blue Ribbon Panel on Black Infant Mortality Reduction. Following release of the report from the panel, an Advisory Panel on Black Infant Mortality was created to implement recommendations from the report including a public awareness campaign and community-based projects to provide outreach and education services in high need communities.

The Northern NJ MCH Consortium has been funded to serve as the Black Infant Mortality Reduction (BIMR) Resource Center under the BIMR Initiative since 1999. The Center acts as a clearinghouse, providing literature, statistics, and other information on BIMR.

Following recommendations from Commissioner Heather Howard's Prenatal Care Task Force, Reproductive and Perinatal Health Services issued a competitive request for applications to improve and provide quality access to prenatal care, preconception and interconception care as a

means to decrease infant mortality rates. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care.

Nine health service grants were awarded for the Access to Prenatal Care Initiative providing statewide representation. The agencies and their activities are described for SPM #1.

#### SP #4. Reduction of Adolescent Risk Taking Behaviors

Creating a Coordinated School Health (CSH) System in NJ to reduce adolescent risk taking behaviors relates to NPM #8, 10, 13, 16 and SPM #4 and 5. The anticipated start date of this project is July 1, 2010. The current DHSS Community Partnerships for Healthy Adolescents (CPHA) initiative, funded in seven counties since 2003, will end with the start-up of the three regional CSH grants. The CPHA initiative conducted a total of 220 activities impacting 51,624 adolescents and addressed these issues: violence prevention including bullying and gangs, improving healthy food choices, increasing physical activity and decreasing TV and other screen time; access to youth-serving health and social services; alcohol, tobacco and other drugs (ATOD), sexuality and prevention of sexually transmitted infections (STIs) including HIV/AIDS, life skill development and heart health.

In 2009 a 5 year cooperative agreement was awarded by the CDC to the Department of Education (DOE) to collaborate with the DHSS on a Coordinated School Health Program to address nutrition, physical activity and tobacco. Three grants, each located in one of three NJ regions (North, Central and South), will be awarded funds to be used for the implementation of CDC's Coordinated School Health model in at least eight public middle- and/or high- schools of public school districts.

#### SP #5. Improving Access to Quality Care for CYSHCN

NJ will continue to improve access to quality care for CYSHCN through collaboration and partnership building, targeting resources and efforts to maintain capacity and to comprehensively address the six MCHB core outcomes for CYSHCN and State Performance Measures (#6, 7, and 8) in order to achieve its State Priority # 5 of Improving Access to Quality Care for CYSHCN.

The network of specialty providers, linkages with enabling services provided by Special Child Health Services Case Management Units (CMUs), collaboration with intergovernmental agencies and community-based organizations (refer to stakeholder list), and leadership from the State agency strengthens the safety net of access to care for NJ's CYSHCN. Although many of NJ's CYSHCN have access to primary care, the coordination of care for medically fragile children is often managed through their specialty providers; Child Evaluation Centers (CECs), Fetal Alcohol Syndrome/and Alcohol Related Neurodevelopmental Disorder (FAS/ARND) Centers, Cleft Lip/Palate Craniofacial Anomalies Centers, Tertiary Care Centers and Ryan White Part D HIV Care Network, and NJ is attempting to reverse that trend. Through the NJ Academy of Pediatrics' Pediatric Council on Research and Education's (PCORE) efforts to promote medical home and the Statewide Parent Advocacy Network's (SPAN's) statewide Systems Integration Grant (SIG) activities, medical home initiatives are being developed to promote collaboration between pediatric subspecialists and primary care providers. NJ is working toward all CYSHCN receiving high quality, comprehensive care through a medical home that assures timely access to necessary pediatric specialty and subspecialty care, community supports, and transition to adult care when appropriate.

NJ continues to work toward ensuring that a sufficient number of pediatric subspecialists are available statewide to provide high quality tertiary care to CYSHCN and endorses the interdisciplinary team approach to comprehensive care.

In addition to autism care being provided by the CECs, 6 Clinical Autism Centers have been partially funded by the Governor's Council for Medical Research and Treatment of Autism/DHSS to enhance their autism diagnostic and treatment services.

Access to appliances including hearing aids, braces, orthotics; and medications for the treatment of asthma/cystic fibrosis is facilitated through the SCHEIS Fee for Service program.

Training and technical assistance for SCHS CMUs, Pediatric Specialty Providers, families and community-based partners on NJ's rapidly evolving health insurance landscape is critical in 2010 and for the near future. In 2008, the NJ Healthcare Reform Act expanded NJ FamilyCare, established a mandate for health care coverage of children, and reformed individual and small employer insurance markets. In addition, recently passed legislation requires State regulated insurance plans to cover certain treatments for autism and other developmental disabilities, including those treatments based on Applied Behavior Analysis. Full and equitable financing by NJ third party payers and State Medicaid remains a challenge but we embrace that challenge to achieve the early identification and management of chronic conditions, comprehensive preventive care, and collaborative practice between primary and subspecialty pediatric care. The landmark federal Patient Protection and Affordable Care Act contains some provisions that have already existed in the NJ individual and small employer markets. However, some provisions that affect children are to be implemented as of July 1, 2010, including plans may not exclude coverage for children under age 19 due to pre-existing conditions and plans may not establish lifetime limits on the dollar value of essential benefits, as well as other significant changes that affect access to care. Dialogue with colleagues in the NJ Department of Banking and Insurance, the SCHS CMUs, Pediatric Specialty Care providers, SPAN's SIG Consortia of Care, PCORE and other stakeholders described earlier will be important to maintain access to care in this changing environment, and community-based trainings on how these changes benefit CYSHCN will be addressed.

Given the high rate of overweight and obesity in CYSHCN, SCHEIS, by joining Shaping NJ and collaborating with other stakeholders, is currently working to draw attention to the obesity prevention needs of CYSHCN.

#### SP #6. Reducing Teen Pregnancy

Teen pregnancy prevention is a state priority for NJ and relates to NPM #8 & SPM #4. Teenage childbearing can have long-term negative effects on both the teenage mother and the infant. Infants born to teen mothers are at higher risk of being low birthweight and preterm. They are also far more likely to be born into families with limited educational and economic resources. Several inter-agency initiatives have been developed to address this priority.

The Advisory Council on Adolescent Pregnancy Prevention was established in 1999 to develop policy proposals, to promote a coordinated and comprehensive approach to the problems of adolescent pregnancy and parenting, and to promote community input and communication. In 2003, the Council developed a 3 year strategic plan. The WorkFirst Teen Pregnancy Prevention Work Group lead by the DHS has been charged with planning, developing and implementing new initiatives. Youth-to-youth programs and mentoring projects and a Teen Pregnancy Resource Center have been established.

DHS, DOE, the Department of Labor and Workforce Development and the Juvenile Justice Commission have collaborated with NJDHSS on the development of statewide County Collaborative Coalitions relative to teen pregnancy prevention activities. Regional forums continue to be held which bring together stakeholders from a variety of agencies and organizations to envision, plan and implement local adolescent pregnancy prevention activities and events for Teen Pregnancy Prevention Month (May).

Title X, NJ Family planning agencies with 58 clinical sites continue to provide comprehensive reproductive health services to adolescents provided free of charge or at a nominal fee. They assure on-going high quality family planning and related preventive health services that will improve the overall health of individuals, with priority for services to individuals from low-income families.

#### SP #7. Decrease Asthma Hospitalizations

Asthma is the most common chronic disease reported in children. It is a leading cause of hospital stays and school absences and poses significant limitations on quality of life for many children and families. Asthma has increased in NJ and worldwide in recent years.

The DHSS Asthma Awareness and Education Program (AAEP) funds the American Lung Association of MidAtlantic (ALAMid), to support the infrastructure of the Pediatric/Adult Asthma Coalition of NJ. The PACNJ implements strategies and initiatives to address the asthma burden, and assist the Department in implementing the State Asthma Strategic Plan. With over 70 members on six task forces, PACNJ works with schools, child care providers, health care providers, health insurers, community groups and environmental agencies to reach all individuals in NJ with the most effective methods for managing their asthma.

Significant accomplishments in the last year are detailed in the section for HSCI #1 (rate of children hospitalized for asthma).

#### SP #8. Improving and Integrating Information Systems

The MCH Epidemiology Program, Family Health Services and the NJDHSS are all involved in efforts to improve and integrate public health information systems. Activities are related to NPM #1, 9, 12 & HSCI #5, 9A, 9B, & 9C. Examples of improving access to and integration of public health information are discussed in sections specific to the performance measures and health systems capacity indicators.

The Electronic Birth Certificate (EBC) System is in the process of being upgraded to a web-based Electronic Birth Registry System (EBRS). The Bureau of Vital Statistics and Registration has involved staff from FHS and the MCH Consortia in the development of an RFP for the EBC upgrade. In addition to improving the timeliness, quality, and security of NJ's birth data, the adoption of a web-based EBRS would also facilitate real-time linkages to other data sets, thus laying the groundwork for the development of an electronic child health registry.

### C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	110905	110634	112406	173	173
Denominator	110905	110634	112406	173	173

Data Source				Newborn Screening Program	Newborn Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	100	100	100	100	100

#### Notes - 2009

Source: Newborn Biochemical Screening Program as reported by the state's Inborn Errors of Metabolism laboratory.

CY 2008 data was entered as provisional 2009 data.

See attached Table - Newborn Screening Disorders FY 2009 Data

#### a. Last Year's Accomplishments

All newborns with confirmed biochemical disorders received appropriate follow-up - see attached chart.

In 2009, New Jersey's Newborn Screening Program implemented screenings for 34 additional conditions; this expansion increased the number of conditions for which newborns receive screening from 20 to 54. The addition of these disorders was in accordance with the Health Resources and Services Administration (HRSA) and the American College of Medical Genetics (ACMG) 2005 report "Newborn Screening: Toward a Uniform Screening Panel and System" recommendation to screen for a minimum of 29 core disorders and 25 secondary conditions. This decision for expansion was also based on recommendations of New Jersey's Newborn Screening Annual Review Committee (NSARC), which was convened in 2005. The expansion places New Jersey in the forefront nationally and aligned with states where screening for these disorders is universally required by law and fully implemented.

Newborn Screening continues to be an essential, preventive public health program for early identification of disorders that can lead to catastrophic health problems. The Newborn Screening and Genetic Services Program, which houses the follow-up component of newborn biochemical screening, ensures that affected newborns and their families receive prompt intervention by contacting primary care providers, physician specialists and parents to ensure evaluation, confirmatory testing, and a final diagnosis. All newborns with confirmed disorders received appropriate follow-up services -- see attached chart.

Newborn screening was instituted in New Jersey in 1964 with the implementation of statewide screening for phenylketonuria (PKU). Screening expanded to include congenital hypothyroidism in 1978, galactosemia in 1982, and the hemoglobinopathies, including sickle cell disease in 1990. With advances in screening technologies and public advocacy for expanded newborn screening, in 2000, the New Jersey Department of Health and Senior Services (DHSS) convened an advisory panel of metabolic and genetic experts, parents, nurses, pediatricians and other health care professionals to closely examine New Jersey's program. Statewide public hearings were also held to enable interested parents, advocates and other concerned individuals the chance to voice their experience and concerns with newborn screening. In 2001, a significant expansion of the program was implemented with the addition of 4 more disorders: Maple Syrup Urine Disease, Cystic Fibrosis, Congenital Adrenal Hyperplasia and Biotinidase Deficiency. In 2002, screening continued to expand in New Jersey with the acquiring of tandem mass spectrometry technology.

By the end of 2003, 12 more metabolic disorders were added to the panel. The last major expansion was completed in 2009 with the additional screening for 34 disorders.

Appropriate educational materials are also provided to hospitals, parents, physicians, and specialists. Educational materials have been prepared for parents and health care professionals. Pediatric specialty consultant groups agreed on using HRSA ACT sheets as a resource for physician information to replace the current physician information sheets at the time of expansion. In order to improve parent informational material, the program adopted new brochures, developed as a result of extensive HRSA and AAP funded studies. The brochures, entitled "These Tests Could Save Your Baby's Life," are available in English and Spanish and have been distributed to all New Jersey birthing facilities.

The DHSS recognizes that screening is only the first step in a state-mandated newborn screening program: successful programs require additional resources and funding to ensure immediate access to confirmatory testing, appropriate treatment and follow-up of each affected infant and family. Due to the nature of some of these disorders, a delay in confirmatory testing and/or treatment can be life threatening. Sub-specialists who can provide these essential services have been identified for the various disorders and funding has been committed to provide a statewide safety net of specialized diagnostic and treatment services.

***An attachment is included in this section.***

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Expanded screenings to include 54 newborn biochemical disorders.			X	
2. 2. Tandem mass spectrometry technology has been implemented in the Newborn Screening Laboratory.			X	
3. 3. Regional specialty care centers have been established and supported for affected newborns and their families.	X			X
4. 4. Ongoing collaboration with specialists and pediatric primary care providers.				X
5. 5. FHS and Public Health and Environmental Lab staff regularly meet with established specialty consultants.			X	X
6. 6. Newborn Screening Annual Review Committee (NSARC) reconvened to advise Newborn Biochemical Screening Program.				X
7. 7. Physician education initiative, consisting of a series of lectures at "grand rounds", web-based CME activities and laminated sheets with NBS management and emergency guidelines.		X		X
8. 8. Improvements in generic NBS parent pamphlets		X		
9. 9. Follow-up protocols, new parent and physician fact sheets for expanded NBS.		X		
10.				

#### **b. Current Activities**

In 2002, SCHEIS began funding for the establishment and provision of specialty services in the areas of genetics/metabolic disorders, pediatric pulmonary and endocrine disorders, and specialty laboratory services.

A subcommittee of the NSARC is reviewing the current policy regarding the retention of residual dried blood spots from newborn screening and is in the process of making recommendations to DHSS. The NSARC will be reviewing Krabbe Disease, SCID, and other conditions for possible

recommendation for inclusion in New Jersey's panel.

Testing, reporting and follow-up of the additional screening tests will continue to be directly managed by the State. To address technological changes that have the potential for improving sensitivity, specificity and the scope of newborn screening services, the NSARC will continue to assess, evaluate, and make recommendations.

For each of the newborn biochemical disorders, semi-annual meetings continue to be held with the respective consultant groups. The purpose of the consultant meetings is to ensure that testing and follow-up procedures used by the State are reflective of best medical and laboratory practices. Additionally, the medical consultants represent the concerns of families with affected newborns, including such diverse issues as insurance reimbursement, obtaining referrals for appropriate medical care and treatment and identification of other unmet needs.

### **c. Plan for the Coming Year**

The Newborn Screening and Genetic Services Program will continue to work with its many partners and consultants including the NSARC in 2011. A review and assessment of disorders such as SCID and Krabbe Disease is expected to be completed. Policy recommendations are expected to be finalized from NSARC concerning the storage and use of residual dried blood spots.

The Program will continue to meet regularly with specialty consultant groups in hematology, endocrinology, pulmonology, and genetic and metabolic medicine to determine appropriate cut-offs for screening tests, as well as follow-up procedures and general program operations.

The Program will continue to be represented and participate in local and national association meetings and activities which are designed to advance newborn screening practice. These include working with the New Jersey Human Genetics Association, the New York Mid-Atlantic Consortium for Genetic and Newborn Screening Services, and the American Association for Public Health Laboratories. The Program will also continue to provide data and respond to surveys as requested by the National Newborn Screening Information System, which is housed in The National Newborn Screening and Genetics Resource Center (NNSGRC). The NNSGRC is a cooperative agreement between the Maternal and Child Health Bureau (MCHB), Genetic Services Branch and the University of Texas Health Science Center at San Antonio (UTHSCSA), Department of Pediatrics.

In 2011, the Program will continue to work on having a module for newborn biochemical screening in the electronic birth certificate. This module would help ensure that all newborns born in New Jersey receive newborn screening and enable easier tracking of affected newborns for follow-up. Web-based updates regarding newborn screening activities, policies and services will be made in accordance with any changes.

## **Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated**

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

<b>Total Births by Occurrence:</b>	<b>108791</b>
<b>Reporting Year:</b>	<b>2008</b>



Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	%
Phenylketonuria (Classical)	108791	100.0	12	4	4	100.0
Congenital Hypothyroidism (Classical)	108791	100.0	1681	68	68	100.0
Galactosemia (Classical)	108791	100.0	88	32	32	100.0
Sickle Cell Disease	108791	100.0	88	32	32	100.0
Biotinidase Deficiency	108791	100.0	20	0	0	
Cystic Fibrosis	108791	100.0	284	21	21	100.0
Homocystinuria	108791	100.0	40	3	3	100.0
Maple Syrup Urine Disease	108791	100.0	2	2	2	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	108791	100.0	1	1	1	100.0
Argininosuccinic Acidemia	108791	100.0	1	1	1	100.0
Citrullinemia	108791	100.0	1	1	1	100.0
Isovaleric Acidemia	108791	100.0	0	0	0	
Propionic Acidemia	108791	100.0	1	1	1	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	108791	100.0	1	1	1	100.0
Methylmalonic acidemia (Cbl A,B)	108791	100.0	0	0	0	
Glutaric Acidemia Type I	108791	100.0	0	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	108791	100.0	6	6	6	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	108791	100.0	0	0	0	

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	60	61	62	56	57
Annual Indicator	57.7	57.7	55.4	55.4	55.4
Numerator					
Denominator					
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	58	59	60	61	61

**Notes - 2009**

Indicator data comes from the National Survey of CSHCN, a numerator and denominator is not available.

**Notes - 2008**

Indicator data comes from the National Survey of CSHCN, a numerator and denominator is not available.

**Notes - 2007**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**a. Last Year's Accomplishments**

Families of CYSHCN are engaged in partnering in decision making across 50 SCHEIS health service grant funded programs including SCHS Case Management, Family WRAP (Wisdom, Resources and Parent to Parent) and Specialized Pediatric Services (SPS); Child Evaluation Centers (CEC's) including Fetal Alcohol Syndrome and Alcohol Related Neurodevelopmental Disorder (FAS/ARND) Centers, Cleft Lip/Palate Craniofacial Centers, and Tertiary Centers. In 2009, multiple methods were used to evaluate CYSHCN/family engagement and satisfaction with services. Program monitoring by State staff included site visits and a review of 10-15 randomly selected records per site documenting agency staff's interaction with CYSHCN and families, such as individualized service plans and narrative notes in client records. Site visits to the SPS providers were conducted on clinic days which afforded State staffs the opportunity to observe interaction between providers and families, and for State monitoring staff to interact directly with families and solicit direct family input regarding the services they were receiving. In addition, self-evaluation was conducted by these agencies periodically throughout the year and included family satisfaction surveys, focus groups and/or quality assurance reviews. Outcomes were used to revise service delivery and were shared with State staffs. Self-identification on family satisfaction surveys is optional for families, input is reviewed by the respective project Coordinators and shared with the State SCHEIS staffs periodically. Likewise, parent input was solicited in the design and revision of SCHS CM, SPS, State SCHEIS program and SPAN Family WRAP

brochures.

Family input was used to, by some Centers, to modify service delivery. For example, the results of a Cleft Lip/Palate Craniofacial Center's family satisfaction survey indicated that upon arrival for their appointments, parents wanted to feel welcomed sooner and to know where they needed to go. Consequently, those results were used to modify operations and a graduate assistant was assigned to greet families at registration and escort them to their team meetings.

SCHEIS partnered in 2009 with SPAN in development of the HRSA sponsored Statewide Implementation Grant (SIG). This initiative has fostered a broad Consortium of Care (COC) for CYSHCN and their families including representatives from intragovernmental, intergovernmental and community-based agencies as well as parents of CYSHCN which promotes achieving the six MCHB core indicators. The COC's efforts included family input and partnership in decision making and satisfaction across each of the indicators. Numerous opportunities for family input are ongoing throughout this initiative. To that end, the COC's 2009 efforts were recognized and have been nominated by the Genetic Alliance to receive the 2010 Art of Novel Partnership Award. The partnership is novel because family leadership and support is at the core of the COC. Together, organizations represent and work to meet the needs of the full diversity of CYSHCN and their families, and the COC engages in continuous quality improvement to enhance outcomes at all levels.

In addition, although not funded by the MCH Block grant, the Ryan White Part D (RWPDP) Family Centered HIV Care Network collaborates with Maternal Child Health Services (MCHS) and SCHEIS programs and serves to ensure access to care. On alternate years the RWPDP conducts needs assessment and patient satisfaction surveys among a large sampling of clients and shares the findings with its Perinatal HIV Advisory Committee which includes MCHS and SCHEIS staff. The findings are valuable in identifying service gaps and retooling services to meet family's needs across the continuum of care.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SPAN		X		X
2. Parent-to-Parent Network		X		X
3. Statewide Family Voices chapter		X		X
4. Family satisfaction surveys, focus groups and/or additional methods of evaluation to be conducted periodically by SCHS CM, Specialized Pediatric Services, Family WRAP providers to measure family satisfaction.		X		X
5. SCHS CMU CDC Surveillance Project		X		
6. Statewide Integrated Systems grant in collaboration with SPAN and Consortium of Care partners		X		
7.				
8.				
9.				
10.				

#### **b. Current Activities**

To ensure family partnership and satisfaction, the SCHEIS ensures access to SCHS case management, family support and specialized pediatric services for CYSHCN and their families. This is being conducted formally through annual State SCHEIS monitoring and technical assistance of the 50 health services grants, as well as through discussion of those agency's findings gathered from family satisfaction surveys, focus groups and quality assurance initiatives.

Consultation and collaboration is provided by State staffs to ensure that findings noted on individualized service plans and progress notes incorporate family driven needs identified by CYSHCN and their families. Likewise, consultation and technical assistance is provided on an as needed basis in developing resources in response to family satisfaction surveys, focus groups and quality assurance initiatives. In addition, SCHEIS collaborates with community-based partners including SPAN, other Consortium of Care members and families to discern family satisfaction and engage parents and CYSHCN in decision making.

### c. Plan for the Coming Year

In addition to maintaining the safety net of health service and family support activities described above, 2011 plans include expanded collaboration with SPAN's SIG and Consortium of Care partners to enhance the collection of family input and satisfaction levels across the six MCHB indicators for CYSHCN. Family input collected through the 50 health service grantees and the SIG will be reviewed by SCHEIS and outcomes will be considered in program review, evaluation and ongoing identification of need. Furthermore, the Birth Defects and Autism Reporting Systems' Centers for Disease Control (CDC) Surveillance project is anticipated to afford State SCHEIS staffs computerized accessibility to individual service plans (ISPs) at the county based SCHS CMUs. The SCHS CMU module is in development and it is anticipated to be piloted 2011. When the ISPs become viewable at the State SCHEIS office, State staffs will be enabled to conduct targeted program monitoring and have increased access to "real time" client needs and services.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	55	56	57	42	43
Annual Indicator	52	52	40.8	40.8	40.8
Numerator					
Denominator					
Data Source				CSHCN Surevy	CSHCN Surevy
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	44	45	46	47	47

#### Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

#### Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

#### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

#### **a. Last Year's Accomplishments**

To ensure access to coordinated, ongoing, comprehensive care within a medical home, SCHEIS has promoted the partnership between CYSHCN, their families and the pediatric teams who oversee the children's health and well-being within a community-based system. Working with community partners including the NJ Academy of Pediatrics' Pediatric Council on Research and Education (PCORE); SPAN and the Consortium of Care (COC) through SPAN's SIG, SCHEIS continued and enhanced its efforts to promote the development of an integrated health system including an interdisciplinary team of patients and families, primary care physicians, specialists and subspecialists, other health professionals, hospitals and healthcare facilities, public health and the community. NJ's safety net of early identification; referral to the SCHS CMUs (21) for case management and family support; specialty care services including comprehensive Child Evaluation Centers (CECs) (11), Autism Clinical Enhancement Centers (6), Tertiary Care Centers (3), Cleft Lip/Palate and Craniofacial Anomalies Centers (5), and Ryan White Part D Family Centered HIV Care Network (7); Genetic Centers (6), Hemophilia Centers (4) and Sickle Cell Centers (5) served over 44,000 CYSHCN. Linkage to primary care and social supports maintained access to the basic elements of comprehensive medical care for NJ's most vulnerable CYSHCN.

In 2009, SCHS CMUs' program data indicated that 98% of CYSHCN served statewide had access to a pediatrician/primary care. Chart review of SCHEIS pediatric specialty providers indicated comparable access to primary care including sharing of specialists' reports and care plans, and in some cases the specialists functioned as the CYSHCN's medical home. However, access to a medical home as defined by the American Academy of Pediatrics remained a challenge.

To that end, the Division of Family Health Services provided a stipend to the NJ Academy of Pediatrics, PCORE to implement a medical home pilot project in Monmouth county. NJ PCORE created a medical home leadership advisory group consisting of members of healthcare agencies, physicians and PCORE staff to provide guidance and expertise for the pilot program; representatives from Early Intervention Services, State SCHEIS, Monmouth County SCHS CMU and SPAN. Eight pilot practices including private, hospital-based and a Federally Qualified Health Center created a medical home team consisting of a physician Practice Champion, a service coordinator and a parent partner. Medical Home indices were administered at each practice and 5 Family Indices were completed as well, the tabulation of findings is in process. In addition, PCORE and leadership advisory group partners organized a statewide medical home forum with regional and national medical home expert speakers, and approximately 100 practitioners and support providers attended. The Monmouth county medical home pilot project provided the foundation for future replication in other regions of NJ through support from PCORE and the SPAN SIG (see current activities and plans for the coming year below).

Ensuring access to a medical home for NJ's most vulnerable, uninsured, underinsured and non-Medicaid eligible populations remained a challenge. However, formal and informal cross referral of CYSHCN and collaborations including SCHEIS and NJ Medicaid, the Medical Assistance Advisory Council (MAAC), Early Intervention, Arc of NJ's Mainstreaming Medical Care, NJ Department of Human Services Medicaid managed care organizations and Division of Developmental Disabilities, Family Voices NJ, PCORE, SPAN and the SCHEIS CMUs and specialty providers ensured that CYSHCN were linked with primary care and specialty services. These collaborations will continue as activities planned for the coming year.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Case Management Services		X		
2. NJ AAP/PCORE Medical Home Projects		X		
3. Medicaid Managed Care Alliances				X
4. Subsidized Direct Specialty and Subspecialty Services	X	X		
5. Participation in Medical Assistance Advisory Council		X		
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Statewide access for NJ's CYSHCN to primary care and SCHEIS subsidized direct specialty and subspecialty services continues. These Child Evaluation Centers continue to provide comprehensive care with a multidisciplinary team approach and assure that CYSHCN receive coordinated, ongoing, comprehensive care, including assistance with care coordination and linkage with a primary care provider/pediatrician. They are recognized by NJ DHS's Medicaid managed care system as Centers of Excellence, are commonly referred clients by community-based providers including pediatricians, child study teams, DCF Child Behavior Health and other community-based providers. Services are provided to the uninsured and underinsured utilizing a sliding-fee-scale and include a comprehensive array of services consistent with the multidisciplinary team approach to advocate for CYSHCN. Additionally, a special insurance program is available for those individuals with Hemophilia A or B who do not have access to any of the traditional insurance programs.

The coordination of care for medically fragile children is often managed through their specialty providers and NJ is attempting to reverse that trend. Through PCORE's efforts with medical home and SPAN's SIG activities, medical home initiatives are being developed to promote collaboration between pediatric subspecialists and primary care providers. Through SPAN's SIG, funding was provided in 2009, to enhance medical home capacity.

**c. Plan for the Coming Year**

Plans for 2011 include formally building upon NJ's Consortium of Care's efforts by SCHEIS State staff, SCHS CMUs and Specialized Pediatric Services providers to collaborate through SPAN's SIG project and PCORE's guidance to facilitate the development of 3 additional medical home initiatives across the northern NJ counties. We anticipate that lessons learned through the early pilot sites, including data from the medical home and family indices and the SIG evaluation data can be applied to future medical home initiatives. Northern NJ includes the most densely populated regions in the State and a large number of specialty services; hospitals and pediatric specialists.

The SCHEIS State staff will continue to support SCHS CMUs, specialty providers, Early Intervention, families and community-based providers in their efforts to link CYSHCN with comprehensive team based specialty care and community-based primary care providers.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

## Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	63	64	64	61	62
Annual Indicator	62.1	62.1	59.9	59.9	59.9
Numerator					
Denominator					
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	63	64	65	66	67

### Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

### Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

### a. Last Year's Accomplishments

Maintaining adequate insurance to pay for CYSHCN's medically necessary health services remained a challenge. Only 2% of the 10,500 CYSHCN with individual service plans and served by the SCHS CMUs were reported as uninsured in 2009, which is consistent with 2008. However, SCHS CMUs and specialty providers noted that the out of pocket expenses attributed to reasonable and customary coverage for specialty services, durable medical equipment, private duty nursing, surgeries, pharmaceuticals and therapies as well as co-pays were difficult for families to afford. Also, Specialized Pediatric Services providers indicated that reasonable and customary reimbursement covered only about 40% of the cost of care delivery. Dental insurance covered about 10% of the orthodontic and pre-surgical dental care needed by CYSHCN with clefts/craniofacial anomalies. In addition, a lack of orthodontic consultants on dental plans that were willing to accept long-term, complicated cleft/craniofacial cases was noted. The SCHEIS and the Catastrophic Illness in Children Relief Fund (CICRF) maintained a letter of agreement to cross refer CYSHCN with catastrophic medical debt. Consequently, the SCHS CMUs reported a 20 %increase in the number of applications generated by the SCHS CMUs in 2009 (320) versus 2009 (256).

The SCHS CMUs and pediatric specialty providers will continue to provide care coordination at no expense to families and to assist in referring families to resources such as Medicaid, New Jersey FamilyCare, NJ Advantage, the Catastrophic Illness in Children Relief Fund program and the Charity Care program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. County Case Management		X		
2. Subsidized Direct Specialty and Subspecialty Services	X	X		
3. Collaborate with the Catastrophic Illness in Children Relief Fund				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Assistance for NJ CYSHCN and their families to access health insurance remains a priority service facilitated by the SCHS CMUs, and Specialized Pediatric Services providers. One hundred percent of CYSHCN referred into these Title V programs are screened for insurance status and provided information and resources regarding health insurance including coverage provided through State and federal programs; SSI, Medicaid waivers, Medicaid, NJ FamilyCare, NJ Advantage and others. In 2008, the NJ Healthcare Reform Act was enacted, The Act expanded NJ FamilyCare, established the nation's first fast track application to a State Children's Health Insurance program by linking data bases to more easily identify and outreach to the uninsured, mandated health care coverage for NJ children, and reformed individual and small employer insurance markets. In 2009, the State's fiscal crisis necessitated a reduction in benefits for some hard to serve populations; i.e., parents and documented aliens are no longer considered eligible applicants. With assistance from the NJ Department of Banking and Insurance and NJ FamilyCare, training for SCHS CMs and Early Intervention service coordinators regarding the components of the NJ Healthcare Reform Act most relevant to CYSHCN is ongoing.

**c. Plan for the Coming Year**

In 2009 the convergence of two NJ Medicaid managed care organizations and introduction of a new plan is resulting in a shift from 5 to 4 Medicaid managed care plans. This reorganization is resulting in nearly 100,000 NJ Medicaid enrollees including some CYSHCN and their families, to make decisions about insurance and provider/specialty access. To avoid fragmentation in access to care, the SCHS CMUs and Pediatric Specialty Providers are conducting outreach to clients in their caseloads to encourage and assist affected families to make a smooth transition to another plan. Ensuring that CYSHCN's primary, specialty, hospital, durable medical providers, and other critical services are enrolled in the receiving plans is vital to maintaining access to comprehensive care.

Additional 2009 State legislation affecting the CYSHCN population served by Title V requires State regulated insurance plans to cover certain treatments for autism and other developmental disabilities, including those treatments based on Applied Behavior Analysis. In addition, Grace's Law recently mandated partial coverage for hearing aids and related services for children under age 16 years. A landmark legislation for hearing impaired CYSHCN, SCHEIS Case Management, Newborn Hearing Screening and Early Intervention staff collaborated with the DHS Division on the Deaf and Hard of Hearing, the Department of Banking and Insurance and families to develop a tool to educate providers and families about how to use Grace's Law.

In addition to current State initiated changes in access to health insurance and the need for Title



V to collaborate with community-based partners to ensure ongoing training for SCHS CMUs, Specialized Pediatric Services providers, community-based providers and families on current private and public health insurance plans, NJ eagerly awaits roll out the Patient Protection and Affordable Care Act (PPACA). This landmark federal health insurance reform is anticipated to close the health insurance coverage gap for many NJ families, including those with CYSHCN. However, confusion among families, primary and specialty providers, hospitals, home health agencies and health insurance plans will require community-based education and accurate technical assistance by SCHS CMUs. Continued dialogue with the SPAN's SIG Consortium of Care, PCORE, the NJ Arc's Mainstreaming Medical Care Advisory Board, the MAAC, and other community-based advocacy groups will be necessary, particularly in this rapidly changing health insurance environment. Given that some of the mandated changes will begin occurring in the next few months, for example plans may not exclude coverage for children under age 19 due to pre-existing conditions, SCHEIS recognizes the urgency in linking the public and providers with accurate and timely information.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	78	79	80	88	90
Annual Indicator	75.9	75.9	88	88	88
Numerator					
Denominator					
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	90	91	91	91	91

#### Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

#### Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

#### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

#### a. Last Year's Accomplishments

In addition to the SCHEIS community-based system of the early identification of CYSHCN; reporting to SCHS CMUs for follow-up and linkage to Specialized Pediatric Services specialty care; community-based healthcare and services; and family support, SCHEIS engaged in intra/intergovernmental, interagency and community-based collaboration to further improve upon the organization of community-based systems. Intra/intergovernmental collaboration included the development and implementation of an enhanced statewide newborn hearing screening follow-up system.

Organizing systems of care to enable families to be linked with pediatric specialized services and/or enhanced capacity without duplication of services, and promoting access to those services to providers and consumers was accomplished through collaboration with State and community-based agencies. The SCHEIS collaborated with the DHSS Division of Long Term Care to revise pediatric medical daycare regulations and facilitate access to specialized care for NJ's most medically fragile CYSHCN. SCHEIS collaborated with MCHS programs and WIC in educating providers and consumers about CYSHCN access to child care, the revised federal formula and food program.

The CYSHCN served by the 11 comprehensive Child Evaluation Centers (CECs) are children with congenital or acquired neurodevelopmental disorders including psychosocial disorders, organic central nervous system disorders, sensory disorders, and communication disorders. CECs are especially suited to serve children with complicated and interconnected health, social and educational needs such as chronic conditions requiring long term care; psychosocial and learning problems; behavioral and environmental effects; and problems related to family stress and parental actions and inactions. In 2009, autism/pervasive developmental disorder ranked second behind attention deficit hyperactivity disorder for diagnostic categories of children served by the CECs. The majority of encounters by unit of service (23%) was to see the CEC physician, and wait times to get an appointment to be evaluated by a pediatric neurodevelopmental specialist ranged from 3-6 months. Enhancing capacity to pediatric neurodevelopmental evaluations through the 6 Autism Clinical Enhancement (ACEs) Centers was implemented, and 3 of the CECs co-house ACEs. Training for CEC based pediatricians in the administration of Autism Diagnostic Observation Schedule testing was organized by the University of Medicine and Dentistry's ACE, with 40 providers participating.

Collaborative efforts between SCHEIS State office and community-based providers, SPAN's SIG activities, NJ PCORE's medical home initiatives and families provided input on the accessibility of community-based services for CYSHCN and their families. NJ PCORE's Monmouth county medical home project included the participation of Parent Partners as a mechanism to support parents of CYSHCN and to enhance care coordination through pediatric practices. Community mapping of county, regional, State and national healthcare resources by the Monmouth county SCHS CMU provided tools for the practice-based care coordinators, Parent Partners and providers to more readily identify service systems to support CYSHCN in their communities.

Enhanced capacity through SPAN's SIG and Parent Training Institute grants supported the SPAN Family WRAP initiative. Five additional SPAN Resource Specialists have been trained and are being housed at SCHS CMUs; Cape May, Cumberland, Burlington, Salem and Gloucester. This collaborative initiative between SPAN, Title V and the SHCS CMU grantees brings the total number of SCHS CMUs with either onsite part-time family support or SPAN designated parent support to 17 counties. These family support specialists are parents of CYSHCN and ensure statewide access to family support, refer to SCHS CMUs, specialty providers and other community-based resources. In 2009, the complement of SPAN Resource Parents provided nearly 16,000 contacts to CYSHCN, attended 69 individualized education plan meetings, 8 mediations, 70 home visits, 6 observations, 1 emergency relief and additional services and supports. In addition, SCHEIS collaborates with SPAN to implement telephonic parent to parent support and technical assistance and support through FamilyVoices NJ.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide Parents Advocacy Network			X	
2. Parent-to-Parent Network			X	
3. Family Voices parent group			X	
4. PCORE			X	
5. SCHS CMUs			X	
6. Child Evaluation Centers				X
7. Autism Clinical Enhancement Centers				X
8.				
9.				
10.				

**b. Current Activities**

The statewide network of SCHEIS services; Case Management, SPAN and the Specialized Pediatric Services providers continue to provide access to community-based accessible services for CYSHCN. During 2010, further collaboration between SPAN Family Resource Specialists, PCORE's medical home Parent Partners, SCHS CMUs, primary and pediatric specialty care providers will continue to provide technical assistance and support to families and/or staff in the areas of specific disabilities and education, as well as transition to preschool and adulthood issues. Efforts to identify additional funding to expand the availability of Resource Parents in each of the Case Management Units as well as the medical home practices are ongoing.

Likewise, the Mercer county SCHS CMU continues to conduct outreach to families of newborns reported to DHSS as lost to follow-up for newborn hearing screening. Staffs are contributing to accurate reporting of newborn hearing screening results to SCHEIS and submitting registrations and/or updates to the BDARS. Combining newborn hearing screening resources, Early Intervention language line supports and the care coordination expertise of SCHS CMUs, Mercer County SCHS has demonstrated success in enhanced follow-up.

The CECs and Autism Clinical Enhancement Centers continue to serve CYSHCN in need of pediatric neurodevelopmental evaluation. Cross referral for additional referrals and/or referral to pediatric tertiary specialty care continues.

**c. Plan for the Coming Year**

As a core team member on SPAN's recently awarded three-year HRSA sponsored State Implementation Grant (SIG) for Systems of Services, SCHEIS plans to expand the availability of a Resource Parent in each county. Likewise, through SIG, SCHEIS plans to enhance capacity at targeted Case Management Units to facilitate participation by local providers on Care Collaboratives. Components of the Care Collaboratives will include teaching pediatric providers how to provide care coordination for CYSHCN, enhancing their knowledge and their practices' family liaisons' knowledge about SCHEIS services, and facilitating linkages with community-based pediatric specialty services.

Continued collaboration between SPAN, SCHEIS and other community-based partners will continue to enhance the provision of accessible family-centered care. SPAN Resource Parents will provide technical assistance and support to families and/or staff in the areas of specific disabilities and education, as well as transition to preschool and adulthood issues through Project Care. SCHEIS will continue to collaborate and partially support a Family Voices chapter. Likewise, SCHEIS will continue to provide intra/intergovernmental and community-based

technical assistance to facilitate access to care for CYSHCN.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	8	10	12	40	41
Annual Indicator	5.8	5.8	37.9	37.9	37.9
Numerator					
Denominator					
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	40	42	44	45	46

#### Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

#### Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

#### Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

#### a. Last Year's Accomplishments

In collaboration with SPAN, SCHS CMUs, parents of CYSHCN and other community-based partners, transition to adulthood packets provided by SCHS CMUs to transitioning youth and their families were updated. The packets include current resources such as local vocational rehabilitation and DHS Division of Developmental Disabilities contacts, guardianship, individual health plan development, Section 504 planning and Americans with Disabilities Act, Social Security and basic rights in transition. As the SCHS CMUs contact active clients approximately 14 years of age for monitoring and/or individualized service plan updates, families are encouraged to develop a goal for their CYSHCN to work toward transition to adulthood. Community-based resources are provided, including information on available transition to adulthood workshops through SPAN, local school districts, Department of Labor Division of Vocational Rehabilitation, as well as the transition to adulthood resource packet. These

resources are revisited at subsequent monitoring.

Due to the economic downturn, unanticipated financial barriers were encountered in organizing the Social Security Alliance's scheduled conference "Expanding Capabilities in Challenging Times." Community partners including the Family Support Organization, the Department of Labor Disabilities Determination, SCHEIS and others determined that the format for the conference needed to be restructured to contain costs and the conference was postponed. The Social Security Alliance will revisit conference planning in 2010.

Collaboration with SPAN's SIG initiative facilitated access to development of a statewide comprehensive plan for transition to adulthood activities. Preliminary planning was initiated to address how to increase CYSHCN's participation in healthcare decision making and access to services; to increase CYSHCN's participation in State and local advisory and leadership goals; and to heighten awareness and identify and implement strategies among providers, organizations and agencies serving CYSHCN to facilitate transition to adult systems of care. Concurrently, Specialized Pediatric Services providers reported conduct of youth targeted activities. Two Cleft lip/palate Craniofacial programs support transition to adulthood efforts conducted through their Center based youth groups.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition to adulthood needs assessment		X		
2. Transition planning for CYSHCN in SCHS Case Management		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Identification and monitoring of transition to adulthood needs for CYSHCN and their families served through the SCHS CMUs statewide is ongoing. Transition packets as noted above are shared with families and linkage with community-based supports is provided.

The SIG transition to adulthood activities are in the further planning and development stages. Community-based partners are identifying resources and linkages are being made through SPAN's transition to adulthood project and community-based organizations that support CYSHCN.

**c. Plan for the Coming Year**

It is anticipated that the Social Security Alliance will retool its conference "Expanding Capabilities in Challenging Times", and reschedule the program. Alliance members will explore options including charging a fee to attend the program.

The SPAN SIG initiative is planning to move forward in development of a Youth Advisory Council (YAC). The YAC is intended to provide a forum for empowering approximately 15 youth to develop leadership and self/group advocacy skills. It is anticipated that the YAC will link with

other YSHCN that are currently informally meeting and participating in self advocacy, to develop a statewide resource and a voice for YSHCN in access to health care, social supports, employment, housing and other needs to establish successful transition to adulthood.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	79	82	83	83	84
Annual Indicator	78.2	78.8	82.3	72.8	73.1
Numerator					
Denominator					
Data Source				NIS, CDC	NIS, CDC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	74	75	76	77	78

#### Notes - 2009

Data from the National Immunization Survey, Q3/2008-Q2/2009. 4:3:1:3:3 rate = 73.1 % (+- 6.5%).

[http://www.cdc.gov/vaccines/stats-surv/nis/tables/0809/tab29\\_43133\\_race\\_iap.xls](http://www.cdc.gov/vaccines/stats-surv/nis/tables/0809/tab29_43133_race_iap.xls).

US rate = 75.0 % (+- 1.1%)

#### Notes - 2008

Data from the 2008 National Immunization Survey. 4:3:1:3:3 rate = 72.8 % (+- 6.1%).

[http://www.cdc.gov/vaccines/stats-surv/nis/tables/08/tab29\\_43133\\_race\\_iap.xls](http://www.cdc.gov/vaccines/stats-surv/nis/tables/08/tab29_43133_race_iap.xls).

US rate = 78.2 % (+- 1.1%)

#### a. Last Year's Accomplishments

Vaccines help prevent infectious diseases and save lives. Vaccines prevent disease in the children who receive them and protect those who come into contact with unvaccinated individuals. Vaccines are responsible for the control of many infectious diseases that were once common in this country, including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, and Haemophilus influenzae type b (Hib).

New Jersey has achieved an 72.8% age appropriate immunization rate in 2008, according to the CDC National Immunization Program. To address age appropriate immunizations (National Performance Measure #7), the Immunization Program in the Division of Communicable Diseases continues to support immunization at clinics in local health departments, Federally Qualified Health Centers (FQHCs), and other pediatric clinics. The State's Vaccines for Children Program became available to private practitioners for the first time in 1999. The Division of Family Health Services (FHS) continues to work collaboratively with the Immunization Program to promote age appropriate immunizations.

The NJIIS (NJ Immunization Information System) is the statewide immunization information system serving as the official repository of immunizations administered to children in New Jersey. The NJIIS has been operating since 1997 and is in use at more than 400 sites throughout New Jersey, with more than 600,000 patient records currently in the system. Most children are enrolled in the system through the electronic birth certificate record process. Each year approximately 70,000 more newborns are enrolled into the system.

The New Jersey Department of Health and Senior Services began the "rolling-out" of a re-designed, web based, statewide universal childhood Immunization Registry in April 2003, through a series of introductory efforts sponsored by the seven regional maternal child health consortia. The New Jersey Immunization Information Registry (NJIIS) is a confidential, population-based, computerized information system that allows NJDHSS to collect and consolidate vaccination data about children within a geographic area. Registries are an important tool to increase and sustain high vaccination coverage by consolidating vaccination records of children from multiple providers, generating reminder and recall vaccination notices for each child, and providing vaccination history documents, and vaccination coverage assessments.

The NJIIS allows providers to obtain a complete and accurate immunization history for a new or continuing patient, produce immunization records, reduce paperwork, manage vaccine inventories, introduce new vaccines or changes in the vaccine schedule, interpret the complex immunization schedule, and provide immunization coverage data for physician offices health plans, and other organizations.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Immunization Program in Communicable Disease				X
2. NJIIS web-based registry			X	
3. NJ Vaccines for Children Program			X	
4. Local health department child health conferences		X		
5. Universal Child Health Record for all children in child care			X	
6. Legislated immunization requirement for school attendance			X	
7.				
8.				
9.				
10.				

#### **b. Current Activities**

All newborn infants in New Jersey are automatically entered into the system at birth via the Electronic Birth Certificate. Interfaces with private insurance carriers have been completed and they will be able to populate the registry as well via physicians accounting entries. A new, nationally sponsored program, NICHQ, has been joined by DHSS and the New Jersey Chapter of the American Academy of Pediatrics to facilitate the introduction of the Immunization Registry into practice sites in targeted areas of particular need. Similar efforts are on going with the Academy of Family Practice of New Jersey as well. The Registry interfaces with the programmatic requirements of WIC and Medicaid.

NJDHSS revised the administrative rules (N.J.A.C. 8:57-4) with substantive changes to include the requirement of four new vaccines (Diphtheria and tetanus toxoids and pertussis vaccine, Pneumococcal conjugate vaccine, Influenza vaccine, and Meningococcal vaccine) for school, preschool and licensed child-care center attendance beginning in September 2008. A summary of

the changes is available at [http://www.state.nj.us/health/cd/documents/vaccine\\_qa.pdf](http://www.state.nj.us/health/cd/documents/vaccine_qa.pdf).

### c. Plan for the Coming Year

FHS continues to work collaboratively with the Immunization Program to promote age appropriate immunizations. All newborn infants in New Jersey are automatically entered into the system at birth via the Electronic Birth Certificate to permit tracking of population-based immunization rates and to promote the completion of immunization schedules through record sharing. Interfaces with private insurance carriers and physician offices will also contribute to populating the registry.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	12.5	12.4	12.3	12.2	12
Annual Indicator	12.3	12.1	12.4	10.0	10.0
Numerator	2216	2184	2233	1755	1755
Denominator	179456	180484	180103	176134	176134
Data Source				BC	BC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	9.8	9.8	9.7	9.6	9.5

#### Notes - 2009

Source: Provisional Electronic Birth Certificate 2008 file as of 6/23/2010, use as provisional 2009 data.

Denominator from <http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/NJ08single.xls>

Final 2009 data will be available in Fall 2011.

#### Notes - 2008

Source: Provisional Electronic Birth Certificate file as of 6/23/2010.

Denominator from <http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/NJ08single.xls>

Final 2008 data will be available in Fall 2010.

### a. Last Year's Accomplishments

The gradual decline in births to adolescents appears to be leveling in New Jersey. According to Guttmacher, although the number of live births to adolescents has declined in recent years, 20% of adolescents who give birth go on to have another child during adolescence. The majority of teen births are unplanned. A major barrier to improvement is that there are fewer healthcare providers of any type in the rural counties and public transportation is virtually nonexistent.

Sixteen family planning agencies with 58 clinical sites provided comprehensive reproductive health services to more than 35,000 adolescents to assist the Title V program in meeting National



Performance Measure # 8, reduction of births to teens 15 - 17 years of age. Clinical services include physical assessment, laboratory testing and individual education and counseling for all FDA approved contraceptive methods.

Family planning agencies also provided community education and outreach to the adolescent population. Aimed at schools and community groups, educational activities that deal with decision-making, value clarification and establishing linkages with youth-serving agencies were encouraged. Educational efforts are directed toward primary pregnancy prevention activities that encouraging family communication, promoting self-esteem, postponing sexual activity and promoting effective contraception. All family planning agencies have implemented an enhanced service package, which for Medicaid beneficiaries is a reimbursable service. The program integrates assessment of adolescent risk behavior within routine family planning services. Through direct individual preventive education or through referral, the program promotes behaviors of healthy lifestyle, injury prevention, drug, alcohol and tobacco prevention, as well as sexually transmitted disease (STD) and pregnancy prevention.

MCH resources also continue to support a Young Fathers Program in Newark. The Program provides counseling services to young men between the ages of 15-23 years to enhance their social and emotional functioning, increase their financial independence, and promote responsible behavior.

The Region II Male Involvement Committee (Region II MAC) serves as a forum for the exchange of information and discussion of issues related to males and male services in Title X Family Planning, funded programs in Region II. After much review, this committee decided that male reproductive health providers needed some guidance in defining the scope of reproductive health services needed for males and to set standards for these services. A newly developed document "Guidelines for Male Sexual and Reproductive Health Services" is intended to be a resource used in the development of clinical services for male clients. Each item includes a statement of the "best practice" followed by a statement of evidence or rationale that supports the best practice and finishes with suggestions for methods to implement the recommendation. The committee recommends that the guide be used as a tool by an agency to develop an organizing structure, outlining male services to be included in their program. This document has been distributed to all Title X Family Planning funded programs and other agencies that have the knowledge and interest in issues related to male family planning services. A staff member of the Family Planning Program in Reproductive & Perinatal Health Services is a member of the Region II MAC.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning Agencies providing comprehensive reproductive services.	X		X	
2. Collaborate with Dept. of Human Services Adolescent Pregnancy Prevention Program.				X
3. Adolescent Pregnancy Prevention Advisory Council				X
4. Community Partnership for Healthy Adolescents Grants				X
5. Adolescent Health Institute				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Title X, NJ Family Planning agencies with 58 clinical sites continue to provide comprehensive reproductive health services to adolescents free of charge or at a nominal fee. They assure on-going high quality family planning and related preventive health services that will improve the overall health of individuals, with priority for services to individuals from low-income families. Reduction in the number of clinic sites may begin in January due to the loss of State funding. The Family Planning agencies are exploring options for changes in the delivery system based on the reduction of funds.

Collaboration with the DHS, the DOE, the Department of Labor and the Juvenile Justice Commission relative to teen pregnancy prevention activities continues to focus on the promotion and development of statewide County Collaborative Coalitions. Regional forums continue to be held which bring together stakeholders from a variety of agencies and organizations to envision, plan and implement local adolescent pregnancy prevention activities for Teen Pregnancy Prevention Month (May).

Presently, this interdepartmental workgroup is drafting a long-range strategic plan, which supports the goals and objectives of sustained adolescent pregnancy prevention services and strategies. Also, intradepartmental planning is underway for the 8th Annual Day of Learning, which has recently broadened in scope to include peer leadership training on teen pregnancy and HIV/STD prevention.

### c. Plan for the Coming Year

Family Planning agencies will continue to provide comprehensive reproductive health services to clients each year to assist the Title V program to meet the National Performance Measure #8, reduction of birth to teens 15 - 17 years of age. All of the Title X funded clinics provide male involvement curriculum and family involvement services.

The Family Planning Program hosts an annual Adolescent Health Institute to bring together adolescent stakeholders from throughout New Jersey to foster networking and collaboration and to provide an opportunity to focus on new information and resources as they pertain to the many issues facing adolescents. Nursing contact hours and certificates of professional development are awarded. The 12th Annual Adolescent Health Institute will be held on November 19th. Topics will include Office of Population Affairs Priorities, Preconceptional Care and Male Involvement in a Family Planning setting.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	44	44	45	45	46
Annual Indicator	40	42	42	46	46
Numerator					
Denominator					
Data Source				Dental Sealant Survey	Dental Sealant Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	46	47	47	48	48

#### **Notes - 2009**

The 2008-2009 oral health survey of third grade children in a sample of elementary schools found that 46% of students had a dental sealant on a permanent molar back tooth.

#### **Notes - 2008**

The 2008-2009 oral health survey of third grade children in a sample of elementary schools found that 46% of students had a dental sealant on a permanent molar back tooth.

#### **Notes - 2007**

During the 2006-2007 dental sealant survey, two additional parent/guardian recall questions were asked as follows: "Has your child ever had a cavity?" Data revealed that 52% of third grade students had a cavity during their lifetime. The other question asked, "Did your child have a dental checkup in the last year?" Data revealed that 87% of third grade students had a dental checkup during the last year.

#### **a. Last Year's Accomplishments**

The Children's Oral Health Program addresses the beginning of the life cycle and oral health through education for women during pregnancy, emphasizing the importance of dental visits, good oral hygiene practices and oral health issues relevant to pregnant women. For children, and adolescents the Program's oral health curriculum supports learning that builds upon prior knowledge emphasizing tooth brushing with a fluoridated toothpaste, regular dental visits, smoking cessation and good dietary practices. In the area of children's oral health, support continues for statewide regional programs that implement a variety of age appropriate oral health education activities for school age children throughout the twenty one counties of the state. Programs include tooth brushing and flossing, use of fluoride as a preventive measure and the school based fluoride mouth rinse program, "Save Our Smiles" which reached approximately 27,000 children in 122 schools during the 2008-2009 school year. The annual mailing of the school newsletter "Miles of Smiles" was mailed to over 3,000 school nurses. This annual publication addresses timely oral health topics of interest, promotes the importance of good oral hygiene practices. Oral health education targeted to school faculty is also included so the school nurse may promote good oral health throughout the school setting.

Collaborative partnerships continue and include the "Homeless Shelter Project Initiative" conducted since 2008 in collaboration with the NJ Dental Hygiene Association that reached over 700 homeless families with children to date, the "Service Learning Collaborative Initiative in conjunction with the Dental Hygiene Program of Burlington County College and a local FQHC, "Protecting Oral Health from Pregnancy to Puberty" Initiative began in 2009 to improve the oral health of pregnant women and to promote good oral hygiene practices for their baby. A variety of newsletters are developed and distributed and include "Oral Hygiene for Children with Special Health Care Needs," WIC and Oral Health,"

Dr. Kupiec-Sce of the Children's Oral Health Program was also invited to participate in and prepare a "Best Practices Collection" of all initiatives undertaken by the Program. New Jersey was one of a very few select states invited to participate by the Association of State and Territorial Dental Directors.

Beginning in 2007, two additional questions were asked on the parent/guardian recall survey pertaining to other dental/oral health issues. In 2009, a total of four additional questions were

asked on the survey. See attachment of additional survey data.

***An attachment is included in this section.***

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Federally Qualified Health Center (FQHC) Expansion				X
2. Physician/Dentist Loan Redemption Program				X
3. Regional Oral Health Promotion Programs			X	X
4. Give Kids a Smile Day			X	X
5. "Save Our Smiles", Fluoride Mouthrinse Program			X	X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The "Cavity Free Kids" Program is targeted to children ages 3-5 years. This program includes daily tooth brushing with fluoridated toothpaste, oral hygiene education, parent education, dental screening referral, and follow-up.

The regional program staff promotes the use of mouth guards for protection from oral injury in school and community-based education programs. In addition, education on the importance of seatbelts and other protection to avoid accidental trauma including oral trauma are emphasized.

The Children's Oral Health Program administers the school-based voluntary weekly "Save Our Smiles" fluoride mouth rinse (FMR) program. The 32-week program represents an active intervention in the Children's Oral Health Program to reduce tooth decay in elementary school children. The FMR program target schools in communities with non-fluoridated community water and having fluoride levels below optimal levels to prevent tooth decay. At the present time, the program provides fluoride using either a mix and pump method or a unit dose system with schools that choose the unit dose system paying the cost difference.

Recognizing that early prevention is necessary for optimal oral health and that pregnancy is an ideal time to educate women about good oral health practices for themselves and their children, the regional program staff have developed and implemented pilot programs for pregnant women.

***An attachment is included in this section.***

**c. Plan for the Coming Year**

Collaboration continues with the New Jersey Dental School and the New Jersey Dental Association to promote the annual "Give Kids a Smile Day" which was held in February, 2010. In addition, The NJ Homeless Shelter Collaboration Project between the Children's Oral Health Program and the NJ Dental Hygiene Association will continue in the coming year and will target 5 shelters in the State and provide oral health education and hygiene instruction to children. The Pregnancy and Oral Health Initiative Collaboration Project between the Children's Oral Health Program and a federally qualified health center will continue to outreach and educate pregnant women. The Service Learning Project between the Children's Oral Health Program and Burlington County College School of Dental Hygiene will again take place. In addition, due to the long standing successful history of the Program, Dr. Kupiec-Sce was contacted by the CDC and was requested to provide consultation and technical assistance (phone and email) on the

development and implementation of a school based fluoride mouth rinse program to the community health faculty at the University of St. Kitts in Basseterre. The request was made due to the long standing successful history of New Jersey's program and the ability to reach high need/high risk children.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	1.6	1.6	1.5	1.3	1.2
Annual Indicator	1.3	1.3	1.7	1.7	1.7
Numerator	23	23	29	29	29
Denominator	1737386	1737386	1693095	1693095	1693095
Data Source				CDC	CDC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	1.6	1.4	1.2	1.1	1.1

#### Notes - 2009

Data source - CDC National Center for Injury Prevention and Control

<http://www.cdc.gov/ncipc/wisqars/>

2007 data is the most recent data available as of 9/15/2010 and has been entered as provisional 2009 data.

#### Notes - 2008

Data source - CDC National Center for Injury Prevention and Control

<http://www.cdc.gov/ncipc/wisqars/>

2007 data is the most recent data available as of 9/15/2010 and has been entered as provisional 2008 data.

#### Notes - 2007

Data source - CDC National Center for Injury Prevention and Control

<http://www.cdc.gov/ncipc/wisqars/>

2007 data is the most recent data available as of 6/23/2010.

Corrected data for:

2004 MVA Deaths 28 MVA Death Rate=1.60.

2005 MVA Deaths 23 MVA Death Rate=1.33.

2006 MVA Deaths 21 MVA Death Rate=1.23.

#### a. Last Year's Accomplishments

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes has declined since 1997 both in New Jersey and in the United States.

In 2008 the NJDHSS Office of Injury Surveillance and Prevention (OISP) convened a panel of

injury prevention experts to provide recommendations in key injury areas which included motor vehicle crashes and unintentional childhood injuries. Recommendations are included in the August 2008 report - Preventing Injury in New Jersey: Priorities for Action.

The main factors that contribute to motor vehicle occupant fatalities in NJ are speed, alcohol, and failure to use restraint options including infant seats, booster seats, and seatbelts. Proper use of occupant restraints plays an important role in reducing fatalities and serious injuries among children in the event of a crash. Seatbelt use in NJ is above the national average, and 2007 data from the NJ Division of Highway Traffic Safety estimated the usage rate at over 91%. A recent "Click it or Ticket" mobilization effort combining education and enforcement resulted in an increase in seat belt use among motorists.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Child Care Initiative safety focus			X	
2. Childhood Lead Poisoning Prevention Project's safety focus				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Although not specifically focused on deaths due to motor vehicle crashes, progress has been made on unintentional injury prevention activities. The Childhood Lead Poisoning Prevention Projects, in addition to providing lead-focused case management, instruct families in child safety including use of infant car seats and child restraint systems. Safety at home and in the child care center is one of the major focuses of the Healthy Child Care New Jersey Initiative.

#### **c. Plan for the Coming Year**

The Healthy Child Care New Jersey Initiative will continue to emphasize safety at home and in the child care center, and has collaborated with the state's Emergency Medical Services for Children program to develop a training curriculum entitled "Anticipating the Unexpected in Child Care Settings". This curriculum has been provided to child care providers in a variety of venues, including the inclusion of related articles in the quarterly Early Childhood Health Link newsletter.

Motor vehicle accidents remain the leading cause of death for teenagers. Teenage drivers are one of the top causes of car accidents. A new law in NJ (Kyleigh's Law) requires probationary drivers, ages 16 to 20, to affix a \$4 pair of red fluorescent decals on their front and rear license plates during a one-year provisional license period. The decals were intended to make it easier for police to identify first-time drivers on the road and ticket them if they violate the provision of the New Jersey's graduated licensing restrictions which prohibit teens from driving between 11 p.m. to 5 a.m., limit car occupants to one other underage passenger, and prohibit any use of "interactive wireless communication."

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		30	42	46	38
Annual Indicator	29	37.3	37.3	53	53
Numerator					
Denominator					
Data Source				NIS, CDC.	NIS, CDC.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	53	53	54	54	55

**Notes - 2009**

2006 data entered for provisional 2009 data.  
Source: National Immunization Survey, CDC.

Final 2009 data may be available from the CDC in 2012.

**Notes - 2008**

2006 data entered for provisional 2008 data. US comparison 43.4% (+- 1.3%)  
Source: National Immunization Survey, CDC.  
[http://www.cdc.gov/breastfeeding/data/NIS\\_data/2006/state\\_any.htm](http://www.cdc.gov/breastfeeding/data/NIS_data/2006/state_any.htm)

Final 2008 data may be available from the CDC in 2011.

**Notes - 2007**

Source: National Immunization Survey, 2005 Births, Centers for Disease Control and Prevention, US Department of Health and Human Services  
[http://www.cdc.gov/breastfeeding/data/NIS\\_data/2005/state\\_any.htm](http://www.cdc.gov/breastfeeding/data/NIS_data/2005/state_any.htm)

New Jersey 37.3±7.4

Final 2007 data may be available from the CDC in 2010.

**a. Last Year's Accomplishments**

In Healthy New Jersey 2010, there are two objectives for breastfeeding: 1) to increase the proportion of mothers who breastfeed their babies at hospital discharge to at least 75.0 percent and 2) to increase the proportion of breastfed infants who are breastfed exclusively at hospital discharge to 90.0 percent. The national breastfeeding objectives are for 75% of mothers to breastfeed in the early postpartum period, for 50% of new mothers to continue breastfeeding until their infants are six months old, for 25% to breastfeed until one year, for 40% to exclusively breastfeed through three months, and for 17% to breastfeed exclusively through six months.

Despite the overwhelming evidence supporting the numerous benefits of and recommendations for exclusive breastfeeding, exclusive breastfeeding rates in the 24 hours prior to hospital discharge in New Jersey continued to decline in 2007 (See Chart 9 attached to Table of

Contents), while any breastfeeding (both breastfeeding and formula feeding) rates continued to increase, yielding an overall increase in breastfeeding initiation rates. In 2007, exclusive breastfeeding at hospital discharge statewide was 35.7% while any breastfeeding (exclusive and combination feeding) was 70.5%.

Breastfeeding rates on discharge varied with the minority composition of mothers. Asian non-Hispanic women were most likely to breastfeed (85.7%) while Black non-Hispanic women were least likely to breastfeed (53.3%). White non-Hispanic and Hispanic women initiated breastfeeding at 69.9% and 75.2% respectively.

The exclusive rates were 47.5% for White non-Hispanic women, 36.1% for Asian non-Hispanic women, 22.8% for Hispanic women, and 21.0% for Black non-Hispanic women. Further examination of the disparity in these rates will require information of locally available breastfeeding promotional activities, protocols, and the cultural appropriateness of those services.

Close collaboration between Maternal and Child Health Services (MCHS) and WIC Services (WIC) is ongoing. Both programs have an interest in breastfeeding protection, promotion and support and have similar constituencies. The CDC Guide to Breastfeeding Interventions was sent to all the delivery hospitals in the State.

In 2008, FHS prepared a report card, Breastfeeding and New Jersey Maternity Hospitals: A Comparative Report (posted at [NJ.gov/health/fhs/professional/breastfeeding\\_report.shtml](http://NJ.gov/health/fhs/professional/breastfeeding_report.shtml)), which is endorsed by the State chapter of the American Academy of Pediatrics (NJ-AAP) and the New Jersey Breastfeeding Task Force. The goal of the report is to present breastfeeding initiation as a quality of care issue, and to promote the included self-assessment tools and model hospital policy recommendations as tools for hospitals to improve their breastfeeding policies and practices.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Professional outreach and education through MCH Consortia.				X
2. Surveillance from the Electronic Birth Certificate (EBC) and Breastfeeding and New Jersey Maternity Hospital Report.			X	X
3. Supporting the development of breastfeeding friendly policies in child care settings.				X
4. Surveillance of breastfeeding through the NJ PRAMS survey.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Many hospitals employ International Board Certified Lactation Consultants who provide early support and information to breastfeeding mothers. WIC Services funds breastfeeding promotion and support services for WIC participants through grants to eight local WIC agencies and three MCH Consortia, which provide services to ten local WIC agencies. WIC lactation consultants and breastfeeding peer counselors provide direct education and support services, literature, and breastfeeding aids, which include breast pumps, breast shells and other breastfeeding aids. WIC breastfeeding staff conducts professional outreach in their communities and education to healthcare providers who serve WIC participants.



### c. Plan for the Coming Year

The report card, Breastfeeding and New Jersey Maternity Hospitals: A Comparative Report, will be updated with 2009 data from New Jersey's delivery facilities. Greater emphasis will be placed on exclusive breastfeeding, both in WIC and at hospitals. There will be strong advocacy for hospitals to adopt the Perinatal Care core measure set, which includes a measure for exclusive breast milk feeding and for hospitals to implement evidence-based best practices for infant feeding. The United States Breastfeeding Committee publication, Implementing the Joint Commission Perinatal Care Core Measure on Exclusive Breast Milk Feeding, will be recommended to the State's delivery facilities as a tool to help them implement the measure on exclusive breast milk feeding.

Strategies to promote breastfeeding will be addressed as part of the Shaping NJ Partnership to prevent childhood obesity. The ONF received a NPAO grant from the CDC to coordinate Nutrition, Physical Activity and Obesity strategies. One of the six target behaviors is to increase breastfeeding duration and exclusivity. A work group of the Shaping NJ Partnership is working on promoting exclusive breastfeeding through changing hospital policies and practices.

### **Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	99	99	99	99.2	99.6
Annual Indicator	98.8	99.2	99.2	99.6	99.6
Numerator	108561	109181	111027	108119	104694
Denominator	109902	110054	111876	108514	105090
Data Source				Newborn Hearing Screening Program	Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	99.7	99.7	99.7	99.7	99.8

#### **Notes - 2009**

Provisional 2009 data from the Newborn Hearing Screening Program based on the EBC which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

Final 2009 data will be available in 2011.

#### **Notes - 2008**

Source: Newborn Hearing Screening Program based on the EBC which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

#### **Notes - 2007**

2007 data from the Newborn Hearing Screening Program based on the EBC which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

#### **a. Last Year's Accomplishments**

Current data indicates that for 2009, 99.6% of infants were screened prior to discharge. Rates for children receiving follow-up after referring on inpatient screening continue to rise, but remain an area requiring improvement.

The Early Hearing Detection and Intervention (EHDI) reporting module in the New Jersey Immunization Information System (NJIS) continues to be utilized by audiologists and other around the state that are conducting follow-up to report outpatient exams with about 85% of reports coming in via this Web-based application instead of on the traditional paper form. Thirty-three new users were trained on the system during 2009.

During 2009, the program attended Pediatric Department business meetings at 4 hospitals, educating 82 physicians. The audiologist began a series of teleconferences for audiologists on a variety of topics, with 11 calls held in 2009 with a total of 238 attendees. Subjects have included a general overview of the EHDI program, a review of EHDI program data, and techniques for doing bone conduction auditory brain stem response testing. Other calls have featured guest speakers from SCHS Case Management, the Division of the Deaf and Hard of Hearing in the Department of Human Services, the New Jersey Statewide Parent to Parent program, and the Department of Education.

The EHDI program held regional meetings for hospital EHDI staff in September and October 2009. In prior years, the EHDI program has conducted an individual performance review with each hospital, either in person or via teleconference. This year, three programs were held in the northern, central and southern locations in the state, with each hospital sending at least one representative to one of the three meetings. At each meeting, two hospitals provided an overview of their own EHDI processes and focused on how they have overcome challenges. Also included was a roundtable discussion of several topics including strategies for improving follow-up. The meetings were very well received and included much sharing of information among peers. The meetings were held on September 25th with 24 attendees, September 30th with 44 attendees, and October 7th with 28 attendees. Individual teleconferences with each hospital began on October 19, 2009 and will continue through May 2010.

The New Jersey Pediatric Hearing Healthcare Directory was updated in July 2009. Annually, audiologists and hearing aid dispensers in New Jersey are asked to verify their current listing and new facilities are added. This resource enables physicians and families to locate facilities in their area that have the required diagnostic services.

The EHDI program collaborated with staff from the Medicaid Office of Quality Assurance to provide a presentation to representatives from the Medicaid managed care organizations (MCOs) on the EHDI process and on enabling MCOs to identify children in their plans that are in need of further hearing evaluation.

The EHDI program utilized supplemental HRSA funding to implement follow-up phone calls to parents and physicians of children in need of hearing follow-up which began in October 2009. While EHDI rules give hospitals the primary responsibility for ensuring children receive appropriate follow-up after discharge, the level of effort put into this by each hospital and the success of their efforts varies widely. Thus this program provides supplemental contacts to complement the hospital's outreach efforts. This outreach is being done via a subgrant arrangement with the Mercer County Case Management Unit. During 2009, the case managers

followed up on 167 families, making at least 267 parent and/or provider contacts.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educational outreach to practitioners (audiologists, pediatricians, otolaryngologists, etc.).				X
2. Hospital level surveillance reports.			X	
3. Increase in follow up and reporting for those who are not screened while inpatient or refer on initial screening.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

In 2010, the EHDI program began a new collaboration with several FQHCs, with supplemental HRSA grant funding. Three FQHCs were selected for funding to purchase equipment and train staff to allow them to conduct outpatient rescreening for infants who did not pass their initial screening. The FQHCs will provide this service at no charge to the families, to reduce the fiscal barriers to lack of newborn hearing screening follow-up.

EHDI staff continues educational presentations to pediatricians, audiologists, otolaryngologists, special child health service case managers, Early Intervention service coordinators, and other health care professionals, focusing on the need to decrease rates of children lost to follow-up.

The EHDI program is continuing the practice of sending hospital-level surveillance data to each hospital with maternity services. A report with overall statistics is sent semi-annually, and in intervening quarters, hospital contacts receive a list of children that are still in need of follow-up after missed or referred inpatient hearing screening.

The NJ Pediatric Hearing Health Care Directory will again be updated in July 2010, and this year will include listings for otolaryngologists, in addition to the previously included audiologists and hearing aid dispensers. Another new resource that will begin to be distributed to parents of children newly diagnosed with hearing loss is a brochure explaining choices in communication options.

#### **c. Plan for the Coming Year**

For 2011, the EHDI program will continue to provide hospital-specific statistics and health care provider education. The Pediatric Hearing Health Care Directory will receive its annual update. A new effort targeted for 2011 will be pilot testing of the use of telehealth application for the provision of early intervention services in New Jersey.

The biennial Family Learning Conference for families with children who are deaf or hard of hearing is currently being planned for May 2011. This conference affords parents of children with hearing loss the opportunity to meet deaf and hard of hearing adults, network with other parents who "have walked in their shoes" and most importantly, to hear from children themselves about growing up with a hearing loss. Since the Family Learning Conference is a family driven event,

normally hearing siblings are also encouraged to attend which adds one more crucial dimension to the family dynamic of raising a child with hearing loss and the role the sibling takes on throughout their lifetime. In addition, it is important for children who are in non-specialized school programs, where they may be the only child with hearing loss in their class. Meeting and networking with other hard of hearing children with similar experiences not only heightens their self-esteem, knowing they are not alone, but they learn what services and technology exists as well as how to advocate for themselves.

**Performance Measure 13:** *Percent of children without health insurance.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	9.5	9	10	12	11
Annual Indicator	11.3	13.6	13.0	11.3	11.3
Numerator	258536		288300	231000	231000
Denominator	2292031		2217692	2044000	2044000
Data Source				CPS	CPS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	11	10.5	10	9.5	9

**Notes - 2009**

Data for 2008 is entered as an estimate for 2009.  
Final 2009 data will be available in Fall 2011.

**Notes - 2008**

Provisional 2008 data from  
Source: U.S. Census Bureau accessed at  
[http://www.census.gov/hhes/www/cpstables/032009/health/h05\\_000.htm](http://www.census.gov/hhes/www/cpstables/032009/health/h05_000.htm)  
Final 2008 data will be available in Fall 2010.

**Notes - 2007**

Source: the Annual Social and Economic Supplement (ASEC) of the Current population Survey (CPS), which is conducted by the Bureau of the Census for the Bureau of Labor Statistics. The age group is children 0-18 years old.  
[http://www.state.nj.us/health/chs/documents/hic00\\_07.pdf](http://www.state.nj.us/health/chs/documents/hic00_07.pdf)  
% uninsured is 13.0 with a numerator of 288,300

**a. Last Year's Accomplishments**

Improving access to preventive and primary care health services for children is a departmental and divisional priority. To provide comprehensive and affordable health insurance to eligible uninsured children, New Jersey and the Federal government have joined as partners in NJ FamilyCare (formerly New Jersey KidCare). NJ FamilyCare, administered by the New Jersey Department of Human Services, started in 1998.

In July 2008 a health care reform bill was signed into law expanding the NJ FamilyCare Program and allowing NJ to reinstitute enrolling parents up to 200% of poverty. The bill also contains a KidsFirst mandate requiring that all children (18-years and younger) have health insurance as of July 2009. Beginning in the 2008 tax year, individuals who file a NJ income tax return must indicate whether their dependents have health insurance and if they do not they will be mailed letters regarding health insurance options. Additionally, there are a number of market reforms in the bill including the introduction of age as a rating factor in NJ's individual insurance market. As of February 2009 there were 556,000 children enrolled in the expanded NJ FamilyCare initiative and 212,000 parents enrolled in the NJ FamilyCare program. In the course of developing NJ FamilyCare, the State learned that many poor children who are eligible for free health insurance under the State's Medicaid program are not enrolled. The aggressive marketing and outreach programs designed to enroll children in NJ FamilyCare are also being used to increase the number of children enrolled in Medicaid. If all children who are eligible for NJ FamilyCare or Medicaid enroll in these programs, then the percentage of children who are uninsured should drop to four percent. Of the approximately four percent of uninsured children who do not qualify for NJ FamilyCare or Medicaid, many experience temporary gaps in insurance coverage, usually as a result of changes in parental employment. If employer-sponsored health insurance continues to decline, NJ FamilyCare will not be able to reduce the overall number of uninsured children in the State. Unfortunately, the percentage of uninsured children in New Jersey has increased from 8.2% in 1999 to 13.0% in 2008.

The NJ Health Care Reform Act of 2008 directed the Commissioner of the Department of Human Services (DHS) to establish the Outreach, Enrollment, and Retention Work Group (Work Group) to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare or NJ FamilyCare ADVANTAGE, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs.

The Work Group's membership includes representatives from the New Jersey Association of Health Plans, Affiliated Computer Services (ACS) Inc., NJ Policy Perspective, Association for Children of NJ (ACNJ), Legal Services of NJ, the NJDHSS, NJDHS, Banking and Insurance, Labor and Workforce Development, Education, Community Affairs, Agriculture, the Office of the Child Advocate and a public member to represent minorities. The Director of Rutgers Center for State Health Policy and representatives from the Department of Children and Families also participated in Work Group meetings.

Data from Rutgers Center for State Health Policy indicate that 293,790 NJ children (13.3 percent) under age 19 lacked health insurance coverage in 2006-07. Approximately 56,070 or 19 percent of these children live in families with incomes over 350 percent of the Federal Poverty Level (FPL) and are eligible for ADVANTAGE. Most of the remaining uninsured children, about 223,720 or 76 percent, are income eligible for free or subsidized coverage through NJ FamilyCare or Medicaid. According to information from DHS, Division of Family Development (DFD), the recession has caused a 50 percent increase in the number of individuals requesting assistance directly from the County Welfare Agencies from December 2007 to December 2008. Given the current economy and increases in the number of unemployed residents, it is likely that the number of uninsured children in NJ will continue to grow.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach and Enrollment Plan				X
2. MOU with NJ FamilyCare				X
3. KidsFirst mandate requiring all children have health insurance				X

4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Recent changes in federal law give states new opportunities to streamline procedures for enrolling children in health insurance programs and improving the efficiency and effectiveness of enrollment and retention practices. NJ is the first state to take advantage of these new opportunities and is in the midst of executing an unprecedented direct outreach campaign. NJ developed an Express application for enrolling children in NJ FamilyCare and Medicaid and is mailing it to the households of the nearly 360,000 children who were identified as uninsured on their 2009 state tax returns.

Based on the Work Group's research and discussion, barriers and recommendations were identified. A report, NJ FamilyCare Outreach, Enrollment and Retention Report May 2009, was produced which identifies findings and recommendations to help meet goals of the Reform Act.

To reduce the number of uninsured children in NJ (NPM #13), Reproductive and Perinatal Health Services continues to work with the Healthy Mothers, Healthy Babies ( HMHB) Coalitions, Healthy Start Projects and Black Infant Mortality Reduction projects to facilitate enrollment of children whose mothers are served by the projects. Due to State budget cuts, new parents are not able to be enrolled.

Atlantic City, Paterson, and Essex County HMHB coalitions have made FamilyCare enrollment one of their priority areas as an access to care issue. Outreach staff assists clients with accessing the system and completing the enrollment process.

#### **c. Plan for the Coming Year**

Recommendations to reduce barriers to health insurance enrollment for children and reduce the number of uninsured children are included in the Work Groups report - NJ FamilyCare Outreach, Enrollment and Retention Report May 2009 (<http://www.acnj.org/admin.asp?uri=2081&action=15&di=1442&ext=pdf&view=yes>).

Despite the fact that all relevant departments are willing to work cooperatively to achieve the goal, additional work is needed to coordinate and implement various activities. A thoughtful planning process among all government entities serving children and families is needed, in concert with technological improvements that will create a streamlined and coordinated assistance program infrastructure. An inclusive planning process to determine which technological improvements are necessary across departmental data systems is in place and moving forward. Federal health insurance reforms and expansion of Medicaid and SCHIP will also positively impact children and families in need of health care services.

Health Service grants funded by Reproductive and Perinatal Health services will continue to require agencies to outreach and facilitate enrollment of potentially eligible children. Outreach to pregnant women will include facilitating access to FamilyCare enrollment to ensure a smooth transition to a pediatric medical home for infants served by the infant mortality reduction projects.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		39	40	39	35
Annual Indicator	39.8	39.1	35.6	35.4	35.9
Numerator	60981	61327			
Denominator	153155	157001			
Data Source				WIC PedNSS	WIC PedNSS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	34	34	34	34	34

**Notes - 2009**

Source: 2009 Pediatric Nutrition Surveillance report for New Jersey, Table 12C. Provided by the NJ WIC Program as compiled by the CDC (see [http://www.cdc.gov/pednss/what\\_is/pednss/index.htm](http://www.cdc.gov/pednss/what_is/pednss/index.htm))

**Notes - 2008**

Source: 2008 Pediatric Nutrition Surveillance report for New Jersey, Table 12C. Provided by the NJ WIC Program as compiled by the CDC (see [http://www.cdc.gov/pednss/what\\_is/pednss/index.htm](http://www.cdc.gov/pednss/what_is/pednss/index.htm))

**Notes - 2007**

Source: 2007 Pediatric Nutrition Surveillance report for New Jersey, Table 12C. Provided by the NJ WIC Program as compiled by the CDC (see [http://www.cdc.gov/pednss/what\\_is/pednss/index.htm](http://www.cdc.gov/pednss/what_is/pednss/index.htm))

Historical data that could not be edited.

% WIC Children 2-5 with BMI  $\geq$ 85%

2006	35.6
2005	35.4
2004	34.5
2003	34.9
2002	33.9
2001	33.0

**a. Last Year's Accomplishments**

Obesity is one of the most serious health problems today. Nationally childhood obesity rates have nearly tripled since 1980, from 6.5 percent to 16.3 percent. The obesity epidemic is taking a toll on the future health of our children by contributing to the rise in related chronic diseases and disabilities, and adding billions of additional dollars in health care costs. Children who are obese are at grave risk of lifelong, chronic health problems like heart disease, asthma, arthritis and cancer. New Jersey has one of the highest obesity rates among low-income children 2 to 5 years of age at nearly 18 percent in 2008, according to the WIC's Pediatric Nutrition Surveillance System.

In 2008, the U.S. Centers for Disease Control and Prevention (CDC) awarded the DHSS Office of Nutrition and Fitness a five year grant to improve the health of at-risk populations in low-income and minority communities. The CDC grant targeted six health and fitness goals: increase breastfeeding, physical activity and consumption of fruits and vegetables; and decrease sugar-sweetened beverages, fatty foods and TV viewing.

The grant directs the state to concentrate its efforts on five settings: schools, communities, child care centers, worksites and health care facilities. New Jersey has established "ShapingNJ," a partnership which currently includes 75 health, education, parks and recreation, agriculture and business organizations.

ShapingNJ enlisted the commitment of diverse partners from across the state to address the obesity epidemic and develop a NJ NPAO State Plan. Partners worked in seven workgroups: physical activity; fruit and vegetable; breastfeeding initiation, duration and exclusivity; TV viewing; energy dense foods and sugar sweetened beverages; Executive and Sustainability Committee; and, Surveillance and Evaluation. ShapingNJ workgroups were directed to 1) focus on policy and environmental change strategies; 2) target resources to those at greatest risk for obesity and other chronic diseases; 3) promote and utilize evidence-based strategies among all partners; and, 4) establish priority populations and strategies, identify available data sources and gaps, and set measurable program objectives.

In 2009 the NJ Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Program introduced a new food package. Changes align the WIC food packages with the 2005 Dietary Guidelines for Americans and current infant feeding practice guidelines of the American Academy of Pediatrics, better promote breastfeeding, provide WIC participants with a wider variety of food, and provide greater flexibility in prescribing food packages to accommodate participants with cultural food preferences.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing collection and reporting of weight and height in the NJ Child Weight Status Report.				X
2. Development of recommendations by the New Jersey Obesity Prevention Task Force.				X
3. New WIC food package.				X
4. Office of Nutrition and Fitness NPOA Grant and formation of the Shaping NJ Partnership.				X
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

In 2010 the current ShapingNJ behavioral workgroups were reorganized by the CDC recommended settings. NPAO partners responsible for the implementation of strategies and activities will be determined and timelines established. Fact-finding focus sessions are being conducted with key groups to determine the feasibility of implementing workgroup developed strategies. NPAO partners will review and approve the completed NJ NPAO State Plan for submission to CDC and their approval. Thereafter, the NJ NPAO State Plan will be evaluated at least annually.



The state's current efforts to combat obesity include health, fitness and safety programs like Safe Routes to School, a program of the New Jersey Department of Transportation (NJDOT) which encourages bicycling and walking. Another NJDOT program, Complete Streets, promotes walking and biking policies in collaboration with local jurisdictions. The Coordinated School Health Program is a CDC-funded program that promotes physical activity, nutrition and tobacco-use prevention among students. The new 2009 Women, Infants and Children (WIC) food package encourages WIC participants to breastfeed and eat more healthy foods.

### c. Plan for the Coming Year

In January 2010, the state passed a law requiring food chains with 20 or more locations nationally to provide calorie counts for food and beverages. The law will take effect in 2011. New Jersey is one of 19 states that have stricter nutritional standards for school lunches, breakfasts and snacks than mandated by federal U.S. Department of Agriculture requirements.

The ShapingNJ Partnership recently received additional federal funding for a two-year obesity prevention initiative, which will be implemented as part of the partnership's strategic plan. For the school setting, Adolescent Health grantees will implement CDC's Coordinated School Health (CSH) model by creating a school health team of diverse composition; analyzing the strengths and weaknesses of existing school health policies, curricula, programs and services using CDC's self assessment tool: the School Health Index (SHI); and, developing an action plan that prioritizes areas for improvement. For the hospital setting, exclusive breastfeeding will be promoted through changing hospital breastfeeding policies and practices.

### **Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective		8	8	7.8	6
Annual Indicator	8.1	8.1	6.2	6.2	6.2
Numerator					
Denominator					
Data Source				NJ PRAMS	NJ PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	5.8	5.6	5.4	5.2	5.2

#### **Notes - 2009**

2007 NJ PRAMS data entered as provisional estimate for 2009. Final 2009 data will be available in 2012.

#### **Notes - 2008**

2007 NJ PRAMS data entered as provisional estimate for 2008. Final 2008 data will be available in 2011.

#### Notes - 2007

Source of data is the NJ PRAMS survey as queried on the CDC PRAMS Ponder system.

Indicator is reported as 6.2% (CI 5.3% - 7.2%).

See NJ PRAMS website (<http://www.state.nj.us/health/fhs/professional/prams.shtml>) for briefs on maternal smoking.

#### Historical data for PM #15

2006	5.7%
2005	6.7%
2004	7.9%
2003	7.9%
2002	9.0%

#### a. Last Year's Accomplishments

Maternal cigarette smoking has negative effects on all stages of pregnancy, from conception to birth. Women who smoke cigarettes have an increased risk of complications, including spontaneous abortion and premature birth. Previous studies have shown that babies exposed to tobacco in utero are more likely to have a low birth weight and are at increased risk for sudden infant death syndrome. Current research suggests that these babies are also less likely to self-soothe and are more aroused and excitable than newborns whose mothers did not smoke during pregnancy. In spite of the negative consequences of maternal smoking on pregnancy outcome, women continue to smoke.

Mom's Quit Connection (MQC) is a grant funded project that offers phone counseling to their pregnant women. They use the 2A's & R approach to smoking cessation. The program educates OB providers about screening their patients and referring them to the MQC program. The MQC program receives over 300 referrals and have been following approximately 80 clients each year. During this past grant year, an additional site has been added. The new program uses face to face counseling and the same 2A's & R approach is used.

An MCHS staff member is a participant in the National Partnership to Help Pregnant Smokers Quit. AMCHP holds quarterly Technical Assistance Conference calls for this group.

Mom's Quit Connection (MQC), a grant funded project that offers phone counseling to pregnant women, MQC teaches the 5 A's approach to quit smoking to professionals to use with their clients.

Statewide there have been many notable accomplishments to reduce smoking. From 2000 to 2007, cigarette taxes were increased from 80 cents per pack to \$2.575 per pack (among the highest in the country). Legislation to ban smoking in all workplaces and indoor public places was passed in 2006. Adult cigarette smoking fell from 21% during the mid 1990s to 17.1% in 2007. NJ's telephone Quitline and internet-based Quitnet have together had over 88,000 users up to the end of 2007.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Mom's Quit Connection offers 5 A's training throughout the state.		X		X
2. The Perinatal Addiction Prevention Project (PAPP) promotes a				X

screening tool that identifies pregnant women who smoke.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Mom's Quit Connection offers 5 A's training throughout the state. These classes are presented to private practitioners as well as large OB/GYN departments.

The Perinatal Addiction Prevention Project (PAPP) promotes a screening tool that identifies pregnant women who smoke. These women are then given referral information for available resources to help them quit. The MCHS staff continues to participate in both the state and national partnerships.

In October 2008 Commissioner Heather Howard launched a campaign to raise awareness about the importance of early prenatal care and preconception health in healthy birth outcomes, including smoking cessation. The educational campaign, A Healthy You = A Healthy Baby, followed the September 2008 release of the Prenatal Care Task Force report, which recommended raising awareness of preconception care and family planning services among women before they get pregnant, to ensure a healthy pregnancy and a healthy baby.

#### **c. Plan for the Coming Year**

The PAPP coordinators will continue to strengthen the referral process once a woman is identified at risk for substance use/abuse.

The federal health care reform legislation included provisions to improve access to smoking cessation services for pregnant women. The new legislation prevents states from excluding tobacco cessation drugs from the medications covered by their Medicaid programs and requires Medicaid to cover smoking cessation treatment for pregnant women, including medication and counseling with no cost-sharing requirements. States that voluntarily cover all recommended preventive services and immunizations for all Medicaid enrollees will get an increase in their federal Medicaid reimbursements.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	3	2.9	2.8	4.2	3.7
Annual Indicator	4.4	4.4	4.1	4.1	4.1
Numerator	26	26	24	24	24
Denominator	585572	588624	589614	589614	589614
Data Source				WISQARS, CDC	WISQARS, CDC

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	3.9	3.8	3.7	3.6	3.5

#### **Notes - 2009**

2007 data entered as provisional estimate for 2009 data. Final 2009 data will be available from the CDC in 2012.

#### **Notes - 2008**

2007 data entered as provisional estimate for 2008 data. Final 2008 data will be available from the CDC in 2011.

#### **Notes - 2007**

Source: WISQARS Injury Mortality Reports online at  
[http://webappa.cdc.gov/sasweb/ncipc/mortrate10\\_sy.html](http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html)

#### **a. Last Year's Accomplishments**

Suicide is the third leading cause of death among adolescents in New Jersey. Suicide rates are highest among non-Hispanic whites. The death rate from suicide for 15-19 year old males is 6.1 per 100,000. The causes of suicide are complex, and have to do with mental illness, particularly depression and/or adverse circumstances. Suicide attempts among younger people tend to be impulsive and communicative acts, often involving non-lethal means. Nearly one third of New Jersey suicide victims in 2003 had diagnosed mental illness at the time of the suicide and about one fifth were reported to have symptoms of depression at the time of their suicide. The major mechanisms used in suicides in New Jersey are firearms, suffocation (usually hanging), and poisoning, although mechanisms varies with age. Firearms and suffocation are the two most lethal means. Females are far more likely than males to use poisoning. Prevention does work. Prevention efforts are increasingly focused on restricting access to lethal means of suicide, especially, but not exclusively, firearms.

The State of New Jersey has taken much action over the past ten years to decrease the risk of completed suicide by children, youth, and young adults. The creation of the State Legislature of the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC) is part of this effort. Kathleen Mackiewicz represents the department on this council. The council will present the NJ State Suicide Prevention State Plan through channels for approval to refine and improve the efforts of its many stakeholders to eliminate suicide. As of 2008 New Jersey ranked 47th lowest of the fifty states for completed suicide rates. The NJYSPAC views this as an excellent indication of the hard work and efforts already put into suicide prevention throughout the state. However, the loss of one life and the promise lost of that person's potential is irrecoverable. The pain and grief that is experienced by the survivors of the loss is immeasurable. Therefore the Council will encourage the state to use this plan to continue and increase the current efforts for suicide prevention.

DHSS supports the Mercer County Traumatic Loss Coalition, which brings together a wide variety of community partners (including schools, local government, police, fire and EMS, and health care providers) to develop plans to prevent and address suicide and other sudden traumatic death among children and adolescents.

A clergy conference, "Suicide: A Compassionate Approach to Intervention and Healing" this time for the Jewish clergy on October 29, 2008. Rabbis, Cantors, religious educators, youth leaders and bereavement group facilitators participated in this event held in West Orange, New Jersey.

Through collaboration with the Department of Human Services and the University of Medicine and Dentistry of New Jersey, the following trainings were provided: There were 341 attendees at the 6th Annual Suicide Prevention Conference "We Have Many Children but None to Spare" held on November 18, 2008 in East Hanover, New Jersey and on November 19, 2008 in Somerset, New Jersey.

A free Trauma and Grief in Youth Workshop was held in three locations: January 5, 2009 at University Behavioral Health Care in Piscataway, New Jersey and on January 6, 2009 in Wayne, New Jersey and on January 8, 2009 in Pomona, New Jersey. Over 380 participants were registered.

The Traumatic Loss Coalitions for Youth publishes a newsletter. Over 3,000 individuals are in receipt of this newsletter.

A full day training on Suicide Assessment of Suicide Events and Grief and Trauma in youth on September 24, 2009, approximately 90 participants attended.

The Mercer County facilitated memorialization protocols for Mercer County schools. They hosted a full day seminar "Adolescent Anxiety and School Refusal" for 120 participants. Nursing contact hours were awarded.

The New Jersey Suicide Prevention quilt was displayed in the resource room at the 11th Annual Adolescent Health Institute on November 13, 2009. 130 school administrators and nurses and family planning providers attended. Nursing contact hours and professional development certificates were provided.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. NJ Youth Suicide Prevention Advisory Council				X
2. Traumatic Loss Coalitions in 21 counties		X		X
3. "Managing Sudden Traumatic Loss in the Schools" - Manual				X
4. Annual Suicide Prevention Conference				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Mercer Traumatic Loss Coalition (a model funded by DHSS and currently there is one in every NJ county) holds monthly Traumatic Loss Meetings. Participants include local school counselors, administration, law enforcement, clergy, and mental health organization staff. Recently the discussion revolved around a local High School regarding recent loss of students. The NJ Suicide Prevention Quilt is displayed and suicide prevention information is distributed in the resource room at the annual Adolescent Health Institute, this year it is scheduled for November 19, 2010. The Traumatic Loss Newsletter is distributed twice a year.

Recent Legislation includes:

AB 3584 requires DHS and DCF to identify available mental health services and perform needs assessment.

HB 3583 requires DHS and DCF to establish standardized admission protocols and medical clearance criteria for admission to behavioral health care facilities.

"Managing Sudden Traumatic Loss in the Schools" (revised edition) is made available to schools and other youth serving organizations upon request. The document outlines a model for responding to the needs of the general school population after a suicide, homicide or sudden accidental death.

The Office of Injury Surveillance and Prevention (OISP) in the Center for Health Statistics is a central source for injury and suicide statistics and several special injury projects. OISP released a report in October 2008 titled Suicide and Firearm Ownership, NJ, 2004-2006.

### c. Plan for the Coming Year

DHSS continues to work with a wide variety of community partners, such as the Mercer County Traumatic Loss Coalition, to develop plans to prevent and address suicide and other sudden traumatic deaths and losses among children adolescents and families.

A Community Response Workshop is scheduled for Summer 2010.

The New Jersey Suicide Prevention quilt will be displayed at the annual Adolescent Health Institute on November 19, 2010

### **Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	85	85	80	80	83
Annual Indicator	80.5	77.6	76.7	82.6	85.6
Numerator	1398	1379	1315	1446	1358
Denominator	1737	1776	1714	1751	1587
Data Source				EBC	EBC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	86	86	87	87	88

#### **Notes - 2009**

Provisional 2009 data from the Electronic Birth Certificate file as of 6/23/2010. Final 2009 data may be available in Fall 2011.

#### **Notes - 2008**

Provisional 2008 data from the Electronic Birth Certificate file as of 6/23/2010. Final 2008 data may be available in Fall 2010.

#### **Notes - 2007**

2007 data from the Electronic Birth Certificate file as of 6/23/2010.

##### **a. Last Year's Accomplishments**

Very low birthweight (LBW) is an important risk factor for future health conditions, disability, and death. Factors that have contributed to this increase are: the increases in multiple births, which are more likely to result in VLBW infants than singleton births (though singleton LBW has also increased); obstetric interventions such as induction of labor and cesarean delivery; infertility therapies; and delayed childbearing.

The state has made progress on NPM #17. However, despite improvements in Neonatal Intensive Care Units (NICU) and community-base efforts that focus on early entry to prenatal care and comprehensive services, we have not observed improvements in the rate of infants born at low birth weights. Overall trends in both low and very low birth weights indicate a small but steady increase in the number of infants born at these weights. A significant refinement in the reporting of LBW rates is the reporting of singleton LBW and singleton VLBW rates as Health Status Indicators. The rapid increase in multiple births due to assisted reproductive technology has influenced overall LBW and VLBW rates. Singleton LBW and singleton VLBW rates are stable or slightly decreasing.

The percent of VLBW infants delivered at facilities for high-risk deliveries and neonates has increased through continuous quality improvement activities, which are coordinated on the regional level by the Maternal and Child Health Consortia (MCHC). The Reproductive and Perinatal Health Services (RPHS) coordinates regional continuous quality improvement activities within each of the 6 regional MCHCs. Regional quality improvement activities include regular monitoring of indicators of perinatal and pediatric statistics and pathology, including 1) transports with death; 2) non-compliance with rules regarding birth weight and gestational age; 3) cases in which no prenatal care was received; 4) all maternal deaths; 5) all fetal deaths over 2,500 grams not diagnosed as having known lethal anomalies; 6) selected pediatric deaths and/or adverse outcomes; 7) immunizations of children 2 years of age; and 8) admissions for ambulatory care sensitive diagnoses in children.

Quality improvement is accomplished through fetal-infant mortality review and maternal mortality review systems, as well as analyzing data collected through the electronic birth certificate (EBC). Currently, all hospitals providing maternity services report births through the EBC. The TQI Committee reviews the data and makes recommendations to address either provider specific issues or broad system issues that address multiple providers or consumer groups within each Consortium region.

As a follow-up to the Perinatal and Pediatric Bed Need Task Force, a statewide collaborative partnership to gather and analyze data related to quality of care for newborn infants and their families was convened. Most of the Regional Perinatal Centers (RPCs) are members of the Vermont Oxford Network (VON) and believe that the prenatal and postnatal data available through this network could improve the system of total quality improvement on a regional and statewide level.

The Directors of Neonatology of the RPCs have been meeting to develop the NJ NICU Collaborative. All 15 RPCs have submitted the documents necessary to participate in the NJ Neonatal Collaborative to establish a statewide reporting program based on the hospital-level NICU performance data submitted to the Vermont Oxford Network, Inc. The 15 centers received the comparative data from VON for the years 2006 and 2007.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Consortia TQI Activities				X
2. Perinatal Designation Level regulations				X
3. MCH Task Force on Hospital-based perinatal and pediatric services				X
4. Development of the New Jersey VON Collaborative				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Directors of Neonatology of the RPCs have been meeting to develop the NJ VON Collaborative. The purpose of the Collaborative is to ensure: the development of a voluntary, collaborative network of neonatal providers, to support a system for bench marking and continuous quality improvement activities for perinatal care; the opportunity to develop a responsive, real time, risk-adjusted, statewide perinatal data system; and the ability to integrate existing state and front-end perinatal data systems.

All of the regional perinatal centers (RPC) in the state currently participate in the NJ NICU Collaborative. The second statewide meeting was held in April 2009 to review major morbidities. Outcomes in NJ are similar to the US. The consensus was to address infection prevention. The initial education effort centered on hand hygiene. The NICU Collaborative achieved active infection reduction activity at all centers.

The NJ NICU collaborative has joined the State Collaborative Group, a sub unit of the Vermont Oxford Network (VON). The Collaborative presented a poster at the 2009 VON NICQ conference.

The Chair of the NJ NICU Collaborative provided a progress report on the infection indicator at the annual March of Dimes NJ Chapter, professional conference. Over 100 health care professionals attended this event.

**c. Plan for the Coming Year**

The New Jersey NICU Collaborative plans to continue to address infections as the common indicator in all of the RPC's. Site visits to include best practices will be conducted regionally. The collaborative has planned six meetings for the year, with three being conducted via the web. Education will be an ongoing goal of the collaborative.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

## Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	79	79	79.2	79.2	79.4



Annual Indicator	77.9	77.1	76.6	78.4	79.5
Numerator	86278	86158	86363	85891	85018
Denominator	110697	111727	112715	109539	106944
Data Source				EBC	EBC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	79.6	79.8	80	80.2	80.2

#### Notes - 2009

Source: 2009 provisional data from the Electronic Birth Certificate file as of 6/23/2010. Final data will be available in 2012.

#### Notes - 2008

Source: 2008 provisional data from the Electronic Birth Certificate file as of 6/23/2010. Final data will be available in 2011.

#### Notes - 2007

Source: 2007 provisional data from the Electronic Birth Certificate file as of 5/6/2009. Final data will be available in 2010.

#### a. Last Year's Accomplishments

In February 2008 a Commissioner's Prenatal Care Task Force was convened to make recommendations to improve access to prenatal care in New Jersey. The Task Force was comprised of physicians, nurses, administrators and others with expertise in maternal and child health. The Task Force presented a report and recommendations to Commissioner Howard in July 2008. Commissioner Howard launched a public awareness campaign statewide using a variety of venues including Healthy Mothers, Healthy Babies, MCH Consortia, hospitals, federally qualified health centers, colleges and others. A request for applications was developed to implement recommendations contained in the Commissioner's Prenatal Care Task Force Report. This competitive request for applications sought to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. It is anticipated that projects seeking funding should be able to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and or increasing access for reproductive age women and their partner for preconception and interconception care. Nine projects were funded within the Access to Prenatal Care Initiative representing a variety of best practice models.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Mothers Healthy Babies coalition activities				X
2. MCH Consortia outreach and education activities				X
3. Commissioner's Prenatal Care Task Force				X
4. Access to Prenatal Care Initiative				X
5.				
6.				

7.				
8.				
9.				
10.				

#### **b. Current Activities**

Based on recommendations from the Prenatal Care Task Force, Infant mortality reduction funding was redirected from Healthy Mothers, Healthy Babies (HM,HB) Coalition outreach and education to the Access to Prenatal Care Initiative request for applications. Activities from the 8 HM,HB Coalition including outreach to identify women in need of prenatal or postpartum care and case management, were phased out during the end of 2009.

#### **c. Plan for the Coming Year**

Following recommendations from the Prenatal Care Task Force, Reproductive and Perinatal Health Services issued a competitive request for applications to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care.

Nine health service grants were awarded for the Access to Prenatal Care Initiative providing statewide representation. The agencies and their activities are described as follows:

Central NJ MCHC will implement a Preconception, Interconception and Prenatal Education awareness campaign targeting women of childbearing age, youth and men in the target area, and will provide a patient navigator to serve at-risk pregnant and/or interconception women within the service region.

Hudson Perinatal Consortium will provide outreach and education, coordination of health benefits including insurance coverage, a medical home, and WIC services for program participants who are entering prenatal care. Hudson Perinatal Consortium will coordinate doula training and childbirth education sessions.

Children's Home Society will target outreach to the Latino and African American community with emphasis on adolescents. Children's Home Society will provide access to prenatal care, interconception and preconception care and outreach and education services in the target area.

Southern Jersey Family Medical Center will provide an integrated service delivery model for reproductive healthcare; partnering with Planned Parenthood of Southern New Jersey and the Southern New Jersey Perinatal Cooperative.

Southern NJ Perinatal Cooperative will establish a regional practice collaborative to foster a comprehensive approach to community awareness, provider training, service integration and improved access to prenatal care, interconception and preconception care.

Northern NJ MCHC will provide a patient navigator model of care with expansion of the Paterson Healthy Mothers Healthy Babies Coalition model.

Gateway Northwest MCH Network will provide a technology based prenatal education/outreach model for pregnant/postpartum clients with special emphasis on adolescents through use of text messaging and email.

Regional Perinatal Consortium of Monmouth and Ocean Counties will provide and coordinate subgrants for direct care including Centering Pregnancy and intensive case management services.

Newark Community Health Center will provide a Centering Pregnancy model with special emphasis on pregnant women with HIV/AIDS.

## D. State Performance Measures

**State Performance Measure 1:** *The percentage of Black non-Hispanic preterm infants in New Jersey*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	13.2	13.1	13	13	13
Annual Indicator	11.5	12.1	11.3	11.0	10.6
Numerator	1866	2039	1945	1861	1744
Denominator	16221	16864	17256	16858	16507
Data Source				EBC	EBC
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	13	12	12	11.5	

### Notes - 2009

Provisional 2009 data from the Electronic Birth Certificate file as of 6/23/2010. Final 2009 data will be available in 2012.

### Notes - 2008

Provisional 2008 data from the Electronic Birth Certificate file as of 6/23/2010. Final 2008 data will be available in 2011.

### Notes - 2007

2007 data from the Electronic Birth Certificate file as of 5/6/2009.

### a. Last Year's Accomplishments

Maternal and Child Health Services chose the percent of black preterm births in New Jersey as State Performance Measure #1. Infants who are born preterm are at the highest risk for infant mortality and morbidity. The percentage of black preterm births was selected to begin to address the underlying causes of black infant mortality and the racial disparity between preterm birth rates.

Maternal and Child Health Services has a long history of addressing perinatal health disparities with special emphasis on the Black Infant Mortality Reduction Initiative which was initiated in 1985. In February 2008 a Commissioner's Prenatal Care Task Force was convened to make recommendations to improve access to prenatal care in New Jersey. Health disparities was identified as a priority. The overall goal of the Access to Prenatal Care Initiative is to increase the rate of first trimester prenatal care in New Jersey to at least 90% to coincide with the National Healthy People 2010 goal, with emphasis on racial and ethnic disparities.

The Department's commitment to reduce black infant mortality has been demonstrated in previous sections concerning the Blue Ribbon Panel on Black Infant Mortality Reduction, the Black Infant Mortality Reduction Advisory Council, the BIBS campaign, the Commissioner's

Prenatal Care Task Force and the Access to Prenatal Care Initiative.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Commissioner's Prenatal Care Task Force				X
2. Access to Prenatal Care Initiative				X
3. Healthy Start		X		X
4. Preconceptual health counseling/training				X
5. Black Infant Mortality Reduction				X
6. MCH Consortia outreach and education activities			X	X
7.				
8.				
9.				
10.				

**b. Current Activities**

Reproductive and Perinatal Services has implemented program evaluation of all funded BIMR activities.

**c. Plan for the Coming Year**

Following recommendations from the Commissioner Prenatal Care Task Force, Reproductive and Perinatal Health Services issued a competitive request for applications to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Projects seeking funding needed to demonstrate the ability to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and/or increasing access for reproductive age women and their partner for preconception care.

Nine health service grants were awarded for the Access to Prenatal Care Initiative providing statewide representation. The agencies and their activities have been previously described in the National Performance Measure #18 section.

**State Performance Measure 2:** *The percentage of Regional MCH Consortia implementing community-based Fetal and Infant Mortality Review (FIMR) Teams.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	6	6	6	6	6
Denominator	6	6	6	6	6
Data Source				Maternal Child & Community Health Service Unit	Maternal Child & Community Health Service Unit
Is the Data Provisional				Final	Final

or Final?					
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	100	100	100	100	

#### **Notes - 2008**

Source: Maternal Child & Community Health Service Unit

#### **Notes - 2007**

Source: Maternal Child & Community Health Service Unit

#### **a. Last Year's Accomplishments**

State Performance Measure #2 was selected to monitor progress toward the implementation of recommendations from community-based Fetal and Infant Mortality Review Teams (FIMR) through Community Action Teams (CATs). This infrastructure building service will impact on National Performance Measures #15, #17, #18 and all of the perinatal outcome measures. Increasing the understanding of the circumstances and factors associated with fetal and infant deaths will advance the State's ability to assess needs, improve the social and health care delivery system, and target resources and policies toward specific locations.

On a local level, the MCH Consortia have used FIMR as a component of their quality improvement program both for need assessment and program development. Findings are shared with member hospitals for use in quality assurance activities. Policy has been implemented, such as the promulgation of fetal autopsy guidelines and consumer and professional education initiatives have addressed findings such as inadequate knowledge of fetal kick count and premature labor, and bereavement support issues.

Until the implementation of the NJ FIMR, there has not been a statewide approach to FIMR. Therefore, FIMR findings have not played a major role in need assessment and quality improvement at the state level. NJDHSS and the MCH Consortia are now working collaboratively to use the information obtained from NJ FIMR for policy development and continuous quality improvement activities on the state and local level. In addition to issuing a Statewide Annual NJ FIMR report, common areas of concern identified from the local reviews will be addressed as a collaborative effort by all local projects through statewide initiatives. Each MCH Consortia has a Community Action Team (CAT) which consists of a diverse group of community leaders. The CAT reviews recommendations from the Case Review Team, prioritizes identified issues and designs and implements intervention in a variety of ways.

Related to FIMR is New Jersey's system of Maternal Mortality Review (MMR), which was established, in the late 1970s and revised in 1999. The revised New Jersey Maternal Mortality Review is based on the National Fetal-Infant review process, using a multidisciplinary model, data abstraction, de-identified case summary, and Community Action Teams to implement programs to effect change. The FHS/Reproductive Health and Perinatal Services coordinates the New Jersey MMR process.

All pregnancy-associated deaths occurring in 1999 through 2005 have been reviewed. The Case Review Team, which also serves as the Community Action Team, has reviewed the findings and made recommendations. A report of the findings and recommendations for the years 1999-2005 is expected in the summer of 2010.

A birth certificate, death certificate and hospital discharge data matching strategy is used to improve identification of maternal deaths using the CDC expanded definition of a pregnancy-associated death. Once cases are identified, Reproductive and Perinatal Health Services verifies the cases by reviewing the death certificate, autopsy report, Report of the Investigation of the Medical Examiner, law enforcement records, or by contacting the hospital or health care provider directly. Cases deemed pregnancy-associated deaths are entered into a log. A copy of the log

and death certificates is forwarded to the Central New Jersey Maternal and Child Health Consortium for data abstraction. The CNJMCHC coordinates data abstraction through a grant from DHSS. Data abstractors are nurses with extensive maternal and child health backgrounds, trained in medical data abstraction, and case summary development.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementing NFIMR in six MCHC Regions.				X
2. Implementation of FIMR process uniformly across all projects.				X
3. Reporting of data and local findings to NJDHSS for inclusion in statewide database.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The number of FIMR projects statewide continues to be 9, of which 7 are funded with MCH Block Grant monies through the 6 regional MCH Consortia. In order to assure a process that will allow for coordination of NJ FIMR findings from a statewide perspective, the process is implemented uniformly across all projects. All local projects of NJ FIMR follow the National FIMR guidelines for community FIMR with modifications as needed for NJ. The data collection process includes both chart abstraction and a maternal interview. A multidisciplinary case review team reviews the information and based on findings, makes recommendations to a Community Action Team. Data and findings from FIMR projects are submitted to the NJDHSS for inclusion in a statewide database.

Obtaining the maternal interview continues to be an impediment to the process. The success in obtaining maternal interviews has improved through the use of nurses through contracting with a local health department or VNA. However, obtaining a maternal interview continues to be a challenge.

**c. Plan for the Coming Year**

All local projects of NJ FIMR will follow the National FIMR guidelines for community FIMR in order to assure a process that will allow for coordination of NJ FIMR findings from a statewide perspective. Data and findings from local FIMR projects will continue to be submitted to the NJDHSS for inclusion in the statewide database. The Reproductive and Perinatal Health Services will continue to coordinate the NJ Maternal Mortality Review process modeled after the National FIMR process.

**State Performance Measure 3:** *The percentage of children with elevated blood lead levels ( $\geq 20$  ug/dL).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2005	2006	2007	2008	2009
----------------------------------	------	------	------	------	------

<b>Data</b>					
Annual Performance Objective	0.3	0.3	0.2	0.2	0.2
Annual Indicator	0.4	0.3	0.2	0.1	0.1
Numerator	628	450	350	261	231
Denominator	173141	179158	161776	175053	175732
Data Source				Childhood Lead Prevention Program Database	Childhood Lead Prevention Program Database
Is the Data Provisional or Final?				Final	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	0.1	0.1	0.1	0.1	

#### **Notes - 2009**

Source: Childhood Lead Prevention Program Database, MCCH, FHS. for 2009. Final 2009 data will be available in Spring 2011.

#### **Notes - 2008**

Source: Childhood Lead Prevention Program Database, MCCH, FHS. for 2008.

#### **Notes - 2007**

Source: Childhood Lead Prevention Program Database, MCCH, FHS. for Federal Fiscal Year 2007.

#### **a. Last Year's Accomplishments**

Children with elevated blood lead levels are at increased risk for behavioral problems, developmental delays, and learning disorders. Increased childhood morbidity will result from undetected and untreated lead poisoning. The percentage of children with elevated blood lead levels (State Performance Measure # 3) was chosen because children in New Jersey have a higher than average exposure to lead in their environment and a higher percentage of elevated blood lead levels than the national average. In CY 08, 0.8% of children tested for lead poisoning in New Jersey had elevated (> 10 ug/dL) blood lead levels.

Significant progress was made toward SPM # 3 regarding childhood lead poisoning prevention. During CY 09, more than 223,000 blood lead tests were reported on 210,833 children. Of the children tested during CY08, 83.5% were under the age of 6 years. Among these children, 0.7% had results > 10 ug/dl and 0.1% had results > 20 ug/dl. Of all the children tested, 101,409 were between six months and 29 months of age, the ages at which state rules require all children to be screened for lead poisoning. This is 45.5% of all children in that age group. Looking at all blood lead tests reported since 1999, it is estimated that 75% of children have had at least one blood lead test by the age of two years, and 54% of children have had at least one blood lead test by the age of 1 year.

The web-based data and surveillance system (LeadTrax) containing medical and environmental case management modules continues to be customized, LeadTrax is CDC data requirements compliant. The LeadTrax user base has been in an incremental expansion mode, by means of hands-on training and access for the users in the remaining local health departments in the State.

During CY 09, because of ongoing efforts, the percentage of electronic reporting increased to 97.4% from the CY 08 rate of 97%. DHSS is in the process of assisting remaining laboratories to make the transition from hard copy to electronic reporting. Through LeadTrax, more laboratories will be able to report electronically because of the system's capability to accept HL7 and Microsoft

Excel reporting templates, which were developed exclusively for screening sites that use LeadCare analyzers.

The project to create Geographical Information System (GIS) maps using childhood lead poisoning data and housing data, exhibiting lead poisoning and screening distribution, along with the distribution of pre-1950 houses in the State, was completed in 2008. This project was through a partnership with DHSS' Center for Cancer Initiatives of New Jersey and the Department of Community Affairs (DCA). The maps were shared with the grantee agencies to help them design their targeted screening and education plans.

Collaborative efforts with Medicaid and its contracted managed care providers continue in order to monitor and increase the number of Medicaid-enrolled children screened for lead poisoning.

In 2008, CDC issued a contract to the National Center for Healthy Housing to provide technical assistance for all areas of Newark's Childhood Lead Poisoning Prevention Program, focusing on strategies that will assure progress toward the goal of eliminating childhood lead poisoning. Initiatives include the development and wide distribution of a resource directory of services needed by families affected or potentially affected by lead poisoning, enhanced collaborations with the city housing authority and other agencies providing housing-related services, and lastly, the development and enforcement of protective policies.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Surveillance system enhancements and universal electronic reporting.			X	X
2. Newark Partnership for Lead Safe Children.			X	X
3. Medicaid collaboration on pilot screening projects.				X
4. Regional Childhood Lead Poisoning Prevention Coalitions.			X	X
5. Plan for Elimination of Childhood Lead Poisoning in New Jersey.				X
6. Nurse case management and environmental investigation protocol enhancements for highest risk jurisdictions ( $\geq 10$ ug/dl).			X	X
7. Targeted screening enhancements (children exposed to parental occupational exposure, refugee children to age 16 years).			X	X
8.				
9.				
10.				

#### **b. Current Activities**

The expansion of the LeadTrax local health department users base continues to be a priority with an expected completion date of December 2010. In February 2010, the NJ DHSS published the combined FY 2008-2009 Annual Report on Childhood Lead Poisoning in New Jersey for dissemination of this data to local health departments and the public.

Focus is on the involvement of child care providers as access points for lead poisoning prevention education, enhancement of community partnerships for resource and referral, and age-appropriate screening of children in collaboration with local health departments and other community-based health care providers.

A conference, scheduled for April 16, 2010, is being planned by the Interagency Task Force on the Prevention of Lead Poisoning to highlight the State's accomplishments and new



collaborations and initiatives that address lead poisoning prevention. The conference's three tracks will focus on health, housing, and the environment. DHSS will continue to provide technical assistance to the thirteen Lead Safe Model Cities in implementing their signed agreements with the Department of the Public Advocate.

### c. Plan for the Coming Year

LeadTrax will be customized further as needed to meet CDC data requirements and data collection requirements due to changes in regulations.

DHSS will continue to place a greater focus on implementing primary prevention initiatives and strengthening strategic partnerships at all levels. State partners include other Divisions and Programs within DHSS (e.g. Refugee Health, Occupational Health, Food and Drug Safety Program), Department of Community Affairs which is responsible for the development and enforcement of state housing codes and standards, Department of Human Services (Medicaid), Department of the Public Advocate, Department of Children and Families, and Department of Environmental Protection. Efforts will focus on identifying and addressing lead hazards prior to young children moving into units or homes, as well as identifying lead-safe housing for families in need of emergency relocation due to a lead poisoned child. Monitoring of the Elimination Plan will be coordinated by DHSS to assure that the state is collectively making progress to eliminate childhood lead poisoning.

In the highest risk city, Newark, the CLPP Program, located within the Newark Department of Child and Family Well-Being, will sustain the Newark Partnership for Lead Safe Children. The Partnership was developed to empower the city and participating organizations to build local capacity to address the lead problem in Newark.

All children in target areas with elevated blood lead levels that require public health intervention are eligible for Childhood Lead Poisoning Prevention (CLPP) Project services as described earlier in this section. Children in other areas of the State with elevated blood lead levels are served by their local health department as required by N.J.A.C. 8:51.

### **State Performance Measure 4:** *The percentage of repeat pregnancies among adolescents 15 - 19 years of age.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	5.8	5.7	5.6	5.5	5.5
Annual Indicator	5.9	6.3	5.7	6.1	6.5
Numerator	408	448	411	426	412
Denominator	6865	7139	7258	6973	6343
Data Source				EBC	EBC
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	5.4	5.4	5.3	5.3	

#### **Notes - 2009**

Provisional 2009 data from the Electronic Birth Certificate file as of 6/23/2010. Final 2009 data will be available in Fall 2011.

#### **Notes - 2008**

Provisional 2008 data from the Electronic Birth Certificate file as of 6/23/2010. Final 2008 data will be available in Fall 2010.

#### Notes - 2007

Provisional 2007 data from the Electronic Birth Certificate file as of 5/6/2009.

#### a. Last Year's Accomplishments

The Adolescent Pregnancy Program at FamCare was transitioned to the Parents as Teachers (PAT) model. FamCare is funded to implement this model by the Department of Children and Families.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive services for teens through Family Planning sites	X			X
2. Adolescent parenting project (AAP)		X		X
3. Advisory Council on Adolescent Pregnancy Prevention completion of a three-year strategic plan				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

Title X, NJ Family Planning agencies with 58 clinical sites continue to provide comprehensive reproductive health services to adolescents free of charge or at a nominal fee. They assure on-going high quality family planning and related preventive health services that will improve the overall health of individuals, with priority for services to individuals from low-income families.

In addressing the Teen Birth Rate and Repeat Teen Birth Rate, collaboration with the DHS, the DOE, the Department of Labor and the Juvenile Justice Commission relative to teen pregnancy prevention activities continues to focus on the promotion and development of statewide County Collaborative Coalitions. Regional forums continue to be held which bring together stakeholders from a variety of agencies and organizations to envision, plan and implement local adolescent pregnancy prevention activities for Teen Pregnancy Prevention Month (May). Presently, this interdepartmental workgroup is drafting a long-range strategic plan, which supports the goals and objectives of sustained adolescent pregnancy prevention services and strategies.

#### c. Plan for the Coming Year

During completion of this year's Needs Assessment, the decision was made to discontinue this State Performance Measure. Current activities to reduce the percentage of repeat pregnancies among adolescents 15 - 19 years of age and teen pregnancy rates (NPM # 8) will continue.

During completion of this year's Needs Assessment, the decision was made to discontinue this State Performance Measure.

**State Performance Measure 5:** *The percentage of State supported initiatives implemented for improving the nutrition and physical activity of children and adolescents*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective		100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	12	12	12	12	12
Denominator	12	12	12	12	12
Data Source				Source: Child & Adolescent Health Programs	Source: Child & Adolescent Health Programs
Is the Data Provisional or Final?				Final	Final
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	100	100	100	100	

#### Notes - 2008

Source: Child & Adolescent Health Programs, FHS.

#### Notes - 2007

Source: Child & Adolescent Health Programs, FHS.

#### a. Last Year's Accomplishments

The NJCPFS funded 22 mini-grants from throughout NJ for promoting health and physical activity in their communities.

As part of the MOA with Rutgers Cooperative Extension the Get Moving, Get Healthy NJ! Website ([www.getmovinggethealthynj.org](http://www.getmovinggethealthynj.org)) aimed at increasing youth and family access to nutrition was launched. In addition, the 9th Childhood Obesity Summit was held in Morris County on November 2nd and 180 stakeholders attended this event aimed at encouraging the community to participate in activities to assist youth and families. A second Child Health Summit is pending as are 8 Family Fun Night events.

Child and Adolescent Health staff and the Office of Local Health are exploring ideas of how MAPP teams and their CHIPs (most reflect obesity as a priority) might be used, as the umbrella for county coalitions (infrastructure), to address nutrition and physical activity, obesity and 5-ADay initiatives. Training for the obesity sub-committee of MAPP team members is being proposed for the OPTF statewide conference.

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Revision of the Obesity Prevention Action Plan to determine priorities.				X
2. Two Community Partnership for Healthy Adolescents grantees are continuing efforts to address nutrition and physical activity with 10-17 year old youth.				X
3. Collaboration with PLAY Task Force and the legislated Interagency Council on Osteoporosis (ICO) on a statewide preschool education initiative for providers, families and pre-school aged children				X
4. Healthy Community Development mini grants		X		X

5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The New Jersey Obesity Prevention Action Plan (OPAP) is being reviewed to meet CDC milestones. The first milestone is that the current plan be revised by partners, rather than a legislated Task Force, who are engaged to contribute or leverage their resources toward the implementation of the plan. Second, a process for establishing priorities, responsibilities for implementation of activities and delineation of timeliness, needs to be completed. Third, measurable program objectives, indicators to measure progress available data sources and methods for determining success have to be determined. Fourth, the OPAP needs to focus on six areas: physical activity, fruit and vegetable consumption, sugar sweetened beverages, energy dense foods, television viewing and breastfeeding. CDC's State plan Index (SPI) is a tool that can be utilized to evaluate the planning process, stakeholder participation, goals and objectives and the methods to implement the strategies; and, ensure that the original OPAP document is enhanced to be aligned with meeting CDC milestones for a NPAO state plan. The state plan will be evaluated at least annually, thereafter. Other than reviewing and revising OPAP, the plan for the coming year is dependent upon approval of DHSS's funding request to CDC.

#### **c. Plan for the Coming Year**

This State Performance Measure (SPM) will be discontinued. Initiatives implemented to improve the nutrition and physical activity of children and adolescents will be addressed by a new SPM - Reduce the proportion of children and adolescents who are overweight or obese. Activities to improve the nutrition and physical activity of children and adolescents are being led by the Office of Nutrition and Fitness and are described in State Priority #2 and NPM # 11 and #14.

**State Performance Measure 6:** *The percentage of children with birth defects who are appropriately reported to the New Jersey Birth Defects Registry.*

#### **Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	87	88	88	89	90
Annual Indicator	88.8	88.8	89.9	89.9	89.9
Numerator	1359	1359	1466	1466	1466
Denominator	1531	1531	1630	1630	1630
Data Source				NJ Birth Defects Registry	NJ Birth Defects Registry
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	90	91	92	92	

#### **Notes - 2009**

Source: 2007 NJ Birth Defects Registry entered as an estimate for 2009 data. Final 2009 data will be available in 2011.

**Notes - 2008**

Source: Provisional 2007 NJ Birth Defects Registry entered as an estimate for 2008 data. Final 2008 data will be available in 2010.

**Notes - 2007**

Source: Provisional NJ Birth Defects Registry. Final data is pending further hospital medical chart audits.

**a. Last Year's Accomplishments**

The NJ Birth Defects Registry (BDR) has been an invaluable tool for surveillance, needs assessment, service planning and research, and to link families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928, and since then, linking registered children to health services. Since 1985, NJ has maintained a population-based BDR of children with all defects. Starting in 2003, the SCHS Registry received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ legislation passed legislation mandating the reporting of Autism. Subsequently, with the adoption of legislative rules in September 2009, the Registry added the Autism Spectrum Diagnoses (ASD) as reportable diagnoses, the Birth Defects Registry was renamed the Birth Defects & Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects to up to age 6, and added severe hyperbilirubinemia as a reportable condition. The system, at present, refers all living children and their families to our SCHS Case Management Units, but does not monitor the progression into the service stream.

The Bloustein Center for Survey Research (BCSR) at Rutgers has been developing a web-based reporting system. This system, upgrades and replaces the former paper-based reporting system. Due to the inclusion of Autism reporting within the BDR, discussions were held with multiple stakeholders, including representatives from SCHS Case Management, Early Intervention, Autism Centers of Excellence, consumers, and national experts to identify the information to be collected on children diagnosed with ASDs. Staff also identified modifications to existing procedures to meet the new legislation requirements. These discussions resulted in the development of a supplemental registration form, now included in the web-based BDARS. On July 1, 2009, the first case was entered into the new web-based BDARS. EIM staff spent most of the second half of 2009 training reporting facilities on the use of the new BDARS.

BCSR continued to work with EIM Program staff and staff from the SCHS county-based Case Management Units to conceptualize the development of the case tracking and management component of the BDARS. As a result of these discussions, BDARS staff developed electronic forms for routine case management activities, including the Individual Family Service Plan (IFSP), child-specific case manager activities, and State and federally required reports. BCSR is at present, developing the SCHS Case Management Module of the BDARS. It is anticipated that this module will be beta-tested in September 2010.

The web-based BDARS electronic registration component, implemented July 2009, will facilitate improvements in reporting from hospitals and medical providers through a secure and HIPAA-compliant Virtual Private Network.

In addition to identifying children through the formal registration process, the Program has continued its quality assurance measures to assure children are properly reported to the BDR. BDR staff identified non-reported children by cooperatively working with birthing hospitals, EHDI Program, and NJEIS.

This past year, the annual audit at all birthing hospitals and one children's specialty hospital to identify children who were not registered was NOT conducted. This was due to the implementation/rolling out of the new BDARS. Starting in July 2009, staff from the Registry were engaged with each birthing facility to train them on the new data system. Each hospital had a minimum of 3 employees trained and educated on the new system. Because of the nature and

length of the training on the new system, the annual on-site audit was not conducted. The system was implemented over the course of 6 months from July 2009 through December 2009. At present all but one birthing hospital is utilizing the BDARS, one hospital had technical difficulties with the version of Java required to run the system and is reporting on paper forms.

A quarterly report, which lists all children registered by the hospital, was sent to each birthing hospital to ensure that all children with mandated birth defects are reported to the SCHS Registry. The Program also worked with the EHDI Program and NJEIS to register children having any level of hearing loss, who were known to these programs, but had not been registered with the SCHS Registry.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Annual Audits				X
2. Collaboration of 1 of 8 National Centers for Birth Defects Research and Prevention Quarterly reports to hospitals.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

BDARS staff are planning to conduct audits for children born in 2008 and 2009. It is anticipated that the audits will begin in September 2010. The annual audits performed by the SCHEIS staff are necessary to identify children with birth defects that would otherwise not be entered into the Registry. The audits, performed at every maternity hospital and facility with pediatric beds, provide an opportunity for Registry staff to present reporting performance back to each facility.

Staff from the BDR conducted site visits and education sessions on the registration process to NJ Early Intervention System providers.

BDR staff continue to collaborate with staff from the Family Centered Care Program (FCCP) to develop a case management module for the electronic BDARS. Staff held meetings with FCCP staff to determine their needs for a case management component for the new BDARS. During these discussions, a standardized approach to collecting, using, and presenting case-related information was developed. This module is scheduled for implementation in the Fall of 2010.

#### **c. Plan for the Coming Year**

The BDARS will improve reporting from hospitals and medical providers as well as improve the information transfer between the Department and the County-based Case Management Units through a secure and HIPAA-compliant Virtual Private Network (VPN).

BDR Staff will provide training to Case Management Units in the use of the electronic BDARS. The BDR staff also will continue to provide assistance to these entities as they transition from the paper-based system to the electronic system. Staff will continue to monitor the implementation of the electronic BDARS and will assist reporting agencies with concerns.

Audits will again be conducted in each of New Jersey's birthing facilities. Audits will also be conducted in each of the 21 County Case Management Units.

Facilities having the lowest levels of appropriate reporting, based upon results of the hospital audit conducted during SFY-2011, will receive remedial assistance from staff of the Birth Defects Registry.

BDR staff will continue to work with the reporting agencies to ensure complete and appropriate reporting of mandated diagnoses, especially during the transition from paper forms to electronic registration. BDR staff will continue to work with the Governor's Council on Medical Research and Treatment of Autism and the Autism Centers to understand the epidemiology of autism in New Jersey.

During completion of this year's Needs Assessment, the decision was made to discontinue this State Performance Measure. Three new State Performance Measures have been added to improve access to quality of care for CYSHCN. The new State Performance Measure concerning the BDARS is the percentage of live children registered with the BDARS who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services.

**State Performance Measure 7:** *Percent of children reported to the NJ Birth Defects Registry by three months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		80	80	80	80
Annual Indicator	63.6	59.9	60.7	52.8	52.8
Numerator	3385	3703	3649	3037	3037
Denominator	5320	6177	6007	5750	5750
Data Source				NJ Birth Defects Registry	NJ Birth Defects Registry
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	80	80	80	80	

**Notes - 2009**

Data for 2008 entered as 2009 estimate pending verification of completeness of 2009 data file. Final 2009 data will be available in 2011.

**Notes - 2008**

Data for 2008 entered as estimate pending verification of completeness of 2008 data file. Final 2008 data will be available in 2010.

**Notes - 2007**

Data for 2007 entered as estimate pending verification of completeness of 2007 data file. Final 2007 data will be available in 2009.

**a. Last Year's Accomplishments**

SPM #7 was originally chosen to measure the timeliness of reporting to the Birth Defects Registry. Because of the link to SCHS Case Management services, though there is no time line for reporting in the legislative rules, the Registry encourages all reporting agencies, but especially

birthing facilities, to report children diagnosed with specific congenital birth defects in a timely fashion. Once reported to the Registry, the registrations are forwarded to the Case Management Units within 14 days.

The NJ Birth Defects Registry (BDR) has been an invaluable tool for surveillance, needs assessment, service planning and research, and to link families to services. Starting in 2003, the SCHS Registry received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ legislation passed legislation mandating the reporting of Autism. The web-based BDARS electronic registration component, implemented on July 1, 2009, facilitates improvements in reporting from hospitals and medical providers through a secure and HIPAA-compliant Virtual Private Network. The case management component will be implemented about 16 months later. Subsequently, with the adoption of legislative rules in September 2009, the Registry added the Autism Spectrum Diagnoses (ASD) as reportable diagnoses, the Birth Defects Registry was renamed the Birth Defects & Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects to up to age 6, and added severe hyperbilirubinemia as a reportable condition.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Audits of charts for a three month period on a yearly basis				X
2. Hospital education				X
3. Collaboration with the NJ Hospital Association				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

Staff from BDR visited each of the birthing facilities in NJ. In attendance were representatives of all pediatric disciplines, nursing, medical records and hospital administration. Included in the presentations by BDR staff were discussions of the importance of registering children as quickly as possible to facilitate the linkage of children with SCHS Case Management (SCHS CM) Units. Quarterly reports were provided to each birthing facility listing all children registered by their institution. Institutions were instructed to promptly review their quarterly reports and verify that all children diagnosed in their facility for the quarter were properly reported. Staff attended quarterly meetings of the SCHS CM Units and stressed the importance of the registration process.

The BDR system, at present, refers all living children and their families to our SCHS CM Units, but does not monitor the progression into the service stream. This past year, the Bloustein Center for Survey Research continued to work with EIM Program staff and SCHS county-based CM Unit staff to conceptualize the development of the case tracking and management component of the BDARS. BDARS staff developed electronic forms for routine case management activities, including the IFSP, child-specific case manager activities, and State and federally required reports. BCSR is at present, developing the SCHS CM Module of the BDARS. This module will be beta-tested in September, with full roll-out in the end of 2010.

#### **c. Plan for the Coming Year**



Staff will continue to stress the importance of quickly reporting children diagnosed as having birth defects. Facilities with untimely reporting to the Registry will be contacted and reminded of the mandate to report and of the importance of the linkage to SCHS Case Management Units. Quarterly reports and a summary table detailing age at time of registration will continue to be provided. During the annual Birth Defects Reporting audit, birthing facilities having reporting times exceeding three months of age for over 25% of their reported children will receive additional training on the importance of the registration process. Hospital staff will be educated as to their importance in the registration process and how faster reports will enable children and families to more quickly obtain services through the SCHS Case Management Units.

The Case Management module of the BDARS will be implemented over the next year. Each of the 21 case management units will be trained in the process and procedures for utilizing this new interface. The electronic reporting component of the BDARS will facilitate more timely reporting by reporting facilities and reduce duplicate reporting as each facility will be able to review all children previously reported by their facility.

During completion of this year's Needs Assessment, the decision was made to discontinue this State Performance Measure. Three new State Performance Measures have been added to improve access to quality of care for CYSHCN. The new State Performance Measure concerning the BDARS is the percentage of live children registered with the BDARS who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services.

**State Performance Measure 8:** *The percentage of HIV exposed newborns receiving appropriate antiviral treatment to reduce the perinatal transmission of HIV.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	74	75	76	77	77
Annual Indicator	82.9	97.0	97.0	97.0	97.0
Numerator	136	128	128	128	128
Denominator	164	132	132	132	132
Data Source				Division HIV/AIDS	Division HIV/AIDS
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
Annual Performance Objective	78	78	78	79	

**Notes - 2009**

Data for 2009 is not currently available (may be available Fall 2011). Data for 2006 entered as provisional 2009 data.

**Notes - 2008**

Data for 2008 is not currently available (may be available Fall 2010). Data for 2006 entered as provisional 2008 data.

**Notes - 2007**

Data for 2007 is not currently available (may be available Fall 2009). Data for 2006 entered as provisional 2007 data.

**a. Last Year's Accomplishments**

The percentage of HIV exposed newborns receiving appropriate antiviral treatment, was selected to focus efforts on reducing the perinatal transmission of HIV. Please note that the data above

has been revised to reflect results from the Survey of Resident Childbearing Women from Division of HIV/AIDS Services, as opposed to previous submissions which have utilized surveillance data from the Division of HIV/AIDS Services.

Early identification and AZT treatment of pregnant women identified as HIV infected appears to be reducing perinatal transmission to newborns. Accurately monitoring the identification and early management of pregnant women and at-risk infants should have a significant impact on reducing the perinatal transmission of HIV. The number of reported cases of HIV/AIDS babies born in NJ dropped from 71 in 1993 to 6 in 2006. Each of NJ's seven Ryan White Title IV Family Centered HIV Care Network Centers has a dedicated perinatal care coordinator responsible for targeting outreach, counseling, testing and long-term follow-up of high-risk adolescents and women of child-bearing age. Pregnant women identified as HIV positive are referred to specialty clinics within the network. AZT treatment is provided during pregnancy, delivery and to newborns according to the CDC protocol. All newborns are referred and managed within the network. Co-located mother-child or family clinics have been established in each site to facilitate long term maintenance of mother and child in care.

Data from the 2006 Survey of Child Bearing Women (SCBW) indicated that 97% of the mothers/newborns received AZT at the time of labor/delivery. This is a marked increase from 13% in 1994, the first year SCBW specimens were tested for AZT. In conjunction with the Division of HIV/AIDS Services, the Network established a Perinatal HIV Advisory Committee in 2000 to develop a statewide policy for rapid testing and short course therapy to reduce the risk of perinatal HIV transmission in women who present in labor with an unknown HIV serostatus. In 2001 the Standard of Care for Women Who Present in Labor with Unknown HIV Serostatus was developed. The intent of the Standard of Care is to provide HIV counseling and voluntary rapid or expedited testing of mothers in labor or delivery, or newborns in nursery units, if there is no documentation of prior HIV testing.

A hospital policy survey designed to assess the institution's ability to comply with the Standard of Care was implemented in 2005. Of particular note, survey responses indicated that the majority of obstetrical hospitals in the state had policies for documenting HIV status in labor and delivery (L&D). Policies for the provision of HIV counseling and rapid testing in L&D, three quarters of hospitals had point-of-care HIV testing in L&D, and two-thirds of hospitals provided anti-retroviral agents to the mother during labor and to the newborn.

As a result of both targeted intervention to pregnant HIV positive women, and administration of appropriate antiretroviral therapy at birth and in subsequent years, the Network has witnessed an aging trend in its population. The trend data demonstrates fewer babies born in New Jersey with HIV infection, and a growing HIV+ adolescent population.

The former data are from the Survey of Childbearing Women in which the percentage of HIV exposed newborns that received appropriate antiretroviral therapy is measured. With the passage of the Codey Bill in 2007, this survey is no longer conducted in New Jersey.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing outreach and education targeting pregnant women		X		
2. Ongoing collaboration with Division of AIDS Prevention and Control				X
3. Transition education for HIV+ youth		X		
4. Development of formal medical and social service transition care plans for adolescents approaching adulthood		X		
5. Ongoing formal Continuous Quality Improvement activities to				X

assess the level of compliance with established health care standards.				
6.				
7.				
8.				
9.				
10.				

#### **b. Current Activities**

The NJDHSS and the Ryan White Part D Network are currently engaged in a needs assessment survey. This survey is completed every other year, opposite a Network-wide patient satisfaction survey. The 2009 survey will focus on the educational needs of consumers.

The Network offers an annual retreat for HIV+ women to help them address the loss of loved ones, cope with the grieving process, deal with chronic illness. An additional annual retreat is held for adolescents to provide education on HIV and sexuality. An annual Case Study Day is offered to medical and social service providers of HIV+ clients annually. This year's topic includes the medical and psychosocial needs of gay, lesbian, and transgendered youth.

The annual Quality Improvement study was completed for 2008. In total, 281 charts were reviewed across 3 age groups, for receipt of medical and social services. Since the inception of a statewide total quality improvement effort in 2001, the pap rate for HIV+ women receiving care at a Network site has increased from 40% to 75%. Another significant change has been the number of children with an undetectable viral load. This number had steadily increased from 26% to 69% in 2008.

The Codey Bill requires health providers to test pregnant women for HIV as part of routine prenatal care. If the mother refuses the test, the newborn shall be tested. The RWPDP Network of providers work with the Division of HIV/AIDS Services to train and to educate NJ providers on this law.

#### **c. Plan for the Coming Year**

The seven Ryan White Part D Family Centered HIV Care Network Centers in New Jersey will continue in the coming year to target outreach, counseling, testing and long-term follow-up of high risk adolescents and women of child bearing age.

During completion of this year's Needs Assessment, the decision was made to discontinue this State Performance Measure. Three new State Performance Measures have been added to improve access to quality of care for CYSHCN.

In collaboration with the DHAS, Title V providers and other community based providers the RWPDP Network will continue to provide training, education and technical assistance to New Jersey providers on the testing of pregnant women and newborns. The RWPDP Network providers will continue to monitor the implementation of the Codey Law within their own practices. The Survey of Childbearing Women, formerly implemented by the DHAS, is now considered unnecessary and efforts will be directed toward providing education on the new law.

### **E. Health Status Indicators**

## Introduction

State MCH program activities have considerable breadth. In order to adequately describe those activities which fall outside the parameters of priority needs and National and State performance measures outlined above, Health Status Indicators are reported separately on the HSI Forms 20 to Forms 21.

Health Status Indicators contribute to your State V agency's ability to assess the MCH needs of the state by providing demographic information on State residents, functioning as evaluative measures, and serving as additional surveillance measures for MCH health. Below are summaries of selected individual Health Status Indicators as they are reported on forms 20 to 21.

### Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	8.2	8.5	8.4	8.4	8.2
Numerator	9045	9494	9494	9233	8726
Denominator	110697	111727	112715	109539	106944
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

#### Notes - 2009

Source of provisional 2009 data is the 2009 Electronic Birth Certificate file (as of 7/12/2010) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ. Final 2009 data will be available in 2011.

#### Notes - 2008

Source of 2008 data is the 2008 Electronic Birth Certificate file (as of 7/12/2010) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

#### Notes - 2007

Source of 2007 data is the 2007 Electronic Birth Certificate file (as of 5/6/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

#### Narrative:

Health Status Indicator # 01A (Low Birth Weight - the percent of live births weighing less than 2,500 grams) as displayed in the attachment IVA Background and Overview graph has been very slowly increasing since 1990. Racial disparities persist between white non-Hispanics and black non-Hispanics. Activities addressing this indicator are discussed in sections related to Health Systems Capacity Indicator 05A and State Performance Measure 1.

### Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
---------------------------------------	------	------	------	------	------

Annual Indicator	6.0	6.2	6.2	6.1	5.9
Numerator	6333	6574	6624	6402	6038
Denominator	105966	106735	107700	104603	102077
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

#### Notes - 2009

Source of provisional 2009 data is the 2009 Electronic Birth Certificate file (as of 7/12/2010) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ. Final 2009 data will be available in 2011.

#### Notes - 2008

Source of provisional 2008 data is the 2008 Electronic Birth Certificate file (as of 7/12/2010) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

#### Notes - 2007

Source of 2007 data is the 2007 Electronic Birth Certificate file (as of 5/6/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

#### Narrative:

Health Status Indicator # 01B (Low Birth Weight - Singleton Births - the percent of live singleton births weighing less than 2,500 grams) has remained level since 1990. With the effect of the large increase in low-birthweight multiple births removed, HSI #01B has remained level. The racial disparity between white non-Hispanics and black non-Hispanics remains unchanged.

#### Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.6	1.6	1.5	1.6	1.5
Numerator	1739	1776	1714	1751	1587
Denominator	110697	111727	112715	109539	106944
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

#### Notes - 2009

Source of provisional 2009 data is the 2009 Electronic Birth Certificate file (as of 7/12/2010) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ. Final 2009 data will be available in 2011.

#### Notes - 2008

Source of 2008 data is the 2008 Electronic Birth Certificate file (as of 7/12/2010) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

**Notes - 2007**

Source of 2007 data is the 2007 Electronic Birth Certificate file (as of 5/6/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

**Narrative:**

Health Status Indicator # 02A (Very Low Birth Weight - the percent of live births weighing less than 1,500 grams) as displayed in the attachment IVA Background and Overview graph has been very slowly increasing since 1990 like HSI #01A. Racial disparity between white non-Hispanics and black non-Hispanics for HIS #02A is even greater than the racial disparity for HSI # 01A.

**Health Status Indicators 02B:** *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Indicator	1.2	1.1	1.1	1.1	1.1
Numerator	1232	1201	1177	1191	1191
Denominator	105966	106735	107700	104603	104603
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2009**

Source of provisional 2009 data is the 2009 Electronic Birth Certificate file (as of 7/12/2010) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ. Final 2009 data will be available in 2011.

**Notes - 2008**

Source of 2008 data is the 2008 Electronic Birth Certificate file (as of 7/12/2010) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

**Notes - 2007**

Source of 2007 data is the 2007 Electronic Birth Certificate file (as of 5/6/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

**Narrative:**

Health Status Indicator # 02B (Very Low Birth Weight - Singleton Births - the percent of live singleton births weighing less than 1,500 grams) has remained level since 1990. With the effect of the large increase in very low-birthweight multiple births removed, HSI #02B has remained level.

**Health Status Indicators 03A:** *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	3.7	3.3	4.5	4.5	4.5
Numerator	65	56	76	76	76
Denominator	1737386	1709703	1693095	1693095	1693095
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2009**

Data for 2009 is not yet available from the CDC.

2007 data is provided as a required estimate for 2009. Final 2009 data may be available in Fall 2012.

**Notes - 2008**

Data for 2008 is not yet available from the CDC.

2007 data is provided as a required estimate for 2008. Final 2008 data may be available in Fall 2011.

**Notes - 2007**

Source: CDC, National Center for Injury Prevention and Control

at WISQARS Injury Mortality Reports - [http://webappa.cdc.gov/sasweb/ncipc/mortrate10\\_sy.html](http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html)

**Narrative:**

Health Status Indicator # 03A (Fatal Unintentional Injuries - the death rate per 100,000 due to unintentional injuries among children aged 14 years and younger) remains the leading cause of death for among children aged 1 to 14 years old. The number per year of specific types of fatal unintentional injuries in New Jersey is small and does not display recent trends.

**Health Status Indicators 03B:** *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.3	1.2	1.7	1.7	1.7
Numerator	23	21	29	29	29
Denominator	1737386	1709703	1693095	1693095	1693095
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
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#### Notes - 2009

Data for 2009 is not yet available from the CDC.

2007 data is provided as a required estimate for 2009. Final 2009 data may be available in Fall 2012.

#### Notes - 2008

Data for 2008 is not yet available from the CDC.

2007 data is provided as a required estimate for 2008. Final 2008 data may be available in Fall 2011.

#### Notes - 2007

Source: CDC, National Center for Injury Prevention and Control

at WISQARS Injury Mortality Reports - [http://webappa.cdc.gov/sasweb/ncipc/mortrate10\\_sy.html](http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html)

#### Narrative:

Motor vehicle crashes remain the leading cause of death for children 1 to 14 years old. Health Status Indicator # 03B (Fatal Unintentional Injuries - the death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes) does not appear to be decreasing.

**Health Status Indicators 03C:** *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	15.2	16.4	14.6	14.6	14.6
Numerator	170	185	165	165	165
Denominator	1115520	1125137	1126489	1126489	1126489
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

#### Notes - 2009

Data for 2009 is not yet available from the CDC.

2007 data is provided as a required estimate for 2009. Final 2009 data may be available in Fall 2012.

#### Notes - 2008

Data for 2008 is not yet available from the CDC.

2007 data is provided as a required estimate for 2008. Final 2008 data may be available in Fall 2011.

#### Notes - 2007



Source: CDC, National Center for Injury Prevention and Control  
at WISQARS Injury Mortality Reports - [http://webappa.cdc.gov/sasweb/ncipc/mortrate10\\_sy.html](http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html)

**Narrative:**

Health Status Indicator # 03C (Fatal Unintentional Injuries - the death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years) may have decreased recently. Motor vehicle crash fatalities remain a leading cause of death for 15 to 24 year olds.

**Health Status Indicators 04A:** *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	186.2	176.5	176.5	176.5	176.5
Numerator	3272	3031	3031	3031	3031
Denominator	1757198	1716883	1716883	1716883	1716883
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2009**

2006 data entered as required estimate for 2009. Final 2009 data may not be available until Fall 2012.

**Notes - 2008**

2006 data entered as required estimate for 2008. Final 2008 data may not be available until Fall 2010.

**Notes - 2007**

2006 data entered as required estimate for 2007. Final 2007 data may not be available until Fall 2010.

**Narrative:**

Health Status Indicator # 04A (Non-fatal Unintentional Injuries - the rate per 100,000 of all nonfatal injuries among children aged 14 years and younger) appears to be decreasing based on the reported data from hospital discharge records.

**Health Status Indicators 04B:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
---------------------------------------	------	------	------	------	------

Annual Indicator	26.9	25.2	25.2	25.2	25.2
Numerator	473	433	433	433	433
Denominator	1757198	1716883	1716883	1716883	1716883
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

#### Notes - 2009

2006 data entered as required provisional estimate for 2009. Final data for 2009 may be available in Fall 2012.

#### Notes - 2008

2006 data entered as required provisional estimate for 2007. Final data for 2007 may be available in Fall 2011.

#### Notes - 2007

2006 data entered as required provisional estimate for 2007. Final data for 2007 may be available in Fall 2010.

#### Narrative:

Health Status Indicator # 04B (Non-fatal Unintentional Injuries - the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger) appears to be decreasing based on the reported data from hospital discharge records.

**Health Status Indicators 04C:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	141.3	116.6	121.4	121.4	121.4
Numerator	1543	1325	1325	1325	1325
Denominator	1091626	1136404	1091626	1091626	1091626
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

#### Notes - 2009

2006 data entered as required provisional estimate for 2009. Final data for 2009 may be available in Fall 2012.

#### Notes - 2008

2006 data entered as required provisional estimate for 2008. Final data for 2008 may be available in Fall 2011.

**Notes - 2007**

Provisional 2006 data entered as required 2007 estimate. Final data for 2007 may be available in Fall 2010.

**Narrative:**

Health Status Indicator # 04C (Non-fatal Unintentional Injuries - the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years) does not display a clear trend based on recent hospital discharge data.

**Health Status Indicators 05A:** *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Indicator	23.0	24.4	24.4	24.4	24.4
Numerator	6595	7031	7031	7031	7031
Denominator	286813	287937	287937	287937	287937
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2009**

2006 data entered as estimate for 2009. Final data for 2009 may be available in Fall 2011.

**Notes - 2008**

2006 data entered as estimate for 2008. Final data for 2008 may be available in Fall 2010.

**Notes - 2007**

2006 Data entered as estimate for 2007. Final data for 2007 may be available in Fall 2009.

**Narrative:**

Health Status Indicator # 05A (Sexually Transmitted Disease (Chlamydia) - the rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia) and Health Status Indicator # 05B (Sexually Transmitted Disease (Chlamydia) - the rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia) are based on data from the Sexually Transmitted Disease Program in the DHSS. The increase in HSI #05A and HSI #05B may represent an increase in the reporting of cases to the DHSS, and increase in the screening for cases or a true increase in the incidence of cases.

**Health Status Indicators 05B:** *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Indicator	7.8	8.2	8.2	8.2	8.2
Numerator	11801	12387	12387	12387	12387
Denominator	1507367	1507367	1507367	1507367	1507367
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

**Notes - 2009**

Data from 2006 entered as a provisional estimate for 2009. Final data for 2009 may be available in Fall 2011.

**Notes - 2008**

Data from 2006 entered as a provisional estimate for 2008. Final data for 2008 may be available in Fall 2010.

**Notes - 2007**

Data from 2006 entered as a provisional estimate for 2007. Final data for 2007 may be available in Fall 2009.

**Narrative:**

Health Status Indicator # 05A (Sexually Transmitted Disease (Chlamydia) - the rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia) and Health Status Indicator # 05B (Sexually Transmitted Disease (Chlamydia) - the rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia) are based on data from the Sexually Transmitted Disease Program in the DHSS. The increase in HSI #05A and HSI #05B may represent an increase in the reporting of cases to the DHSS, and increase in the screening for cases or a true increase in the incidence of cases.

**Health Status Indicators 06A:** *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

<b>CATEGORY</b>	<b>Total All Races</b>	<b>White</b>	<b>Black or African American</b>	<b>American Indian or Native Alaskan</b>	<b>Asian</b>	<b>Native Hawaiian or Other Pacific Islander</b>	<b>More than one race reported</b>	<b>Other and Unknown</b>
<b>TOTAL POPULATION BY RACE</b>								
Infants 0 to 1	111646	78992	21854	645	10155	0	0	0
Children 1 through 4	445315	322498	79866	1809	41142	0	0	0
Children 5 through 9	554317	407322	97722	2514	46759	0	0	0
Children 10 through 14	581817	431502	102672	2604	45039	0	0	0
Children 15 through 19	589614	440645	107750	2639	38580	0	0	0

Children 20 through 24	536875	402055	97593	2696	34531	0	0	0
Children 0 through 24	2819584	2083014	507457	12907	216206	0	0	0

#### Notes - 2011

##### Narrative:

An overview of demographic trends including HSI #06A & B (Demographics -Total Population) and HSI #07A & B (Demographics -Total live births) are provided in section III. A. State Overview. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

#### Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

##### HSI #06B - Demographics (TOTAL POPULATION)

<b>CATEGORY</b> TOTAL POPULATION BY HISPANIC ETHNICITY	<b>Total NOT Hispanic or Latino</b>	<b>Total Hispanic or Latino</b>	<b>Ethnicity Not Reported</b>
Infants 0 to 1	81288	30358	0
Children 1 through 4	337779	107536	0
Children 5 through 9	444115	110202	0
Children 10 through 14	480030	101787	0
Children 15 through 19	487388	102226	0
Children 20 through 24	432160	104715	0
Children 0 through 24	2262760	556824	0

#### Notes - 2011

##### Narrative:

An overview of demographic trends including HSI #06A & B (Demographics -Total Population) and HSI #07A & B (Demographics -Total live births) are provided in section III. A. State Overview. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

#### Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

##### HSI #07A - Demographics (Total live births)

<b>CATEGORY</b> Total live births	<b>Total All Races</b>	<b>White</b>	<b>Black or African American</b>	<b>American Indian or Native Alaskan</b>	<b>Asian</b>	<b>Native Hawaiian or Other Pacific Islander</b>	<b>More than one race reported</b>	<b>Other and Unknown</b>
Women < 15	104	49	52	0	0	0	0	3
Women 15 through 17	2184	1134	894	0	19	0	0	137
Women 18 through 19	4955	2867	1804	0	40	0	0	244

Women 20 through 34	80408	54817	13877	0	8064	0	0	3650
Women 35 or older	24076	18305	2942	0	2108	0	0	721
Women of all ages	111727	77172	19569	0	10231	0	0	4755

#### Notes - 2011

##### Narrative:

An overview of demographic trends including HSI #07A & B (Demographics -Total live births) are provided in section III. A. State Overview. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

#### Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

##### HSI #07B - Demographics (Total live births)

<b>CATEGORY</b>	<b>Total NOT Hispanic or Latino</b>	<b>Total Hispanic or Latino</b>	<b>Ethnicity Not Reported</b>
Total live births			
Women < 15	55	49	0
Women 15 through 17	1140	1044	0
Women 18 through 19	2727	2221	0
Women 20 through 34	58584	21710	0
Women 35 or older	20192	3865	0
Women of all ages	82698	28889	0

#### Notes - 2011

##### Narrative:

An overview of demographic trends including HSI #07A & B (Demographics -Total live births) are provided in section III. A. State Overview. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

#### Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

##### HSI #08A - Demographics (Total deaths)

<b>CATEGORY</b>	<b>Total All Races</b>	<b>White</b>	<b>Black or African American</b>	<b>American Indian or Native Alaskan</b>	<b>Asian</b>	<b>Native Hawaiian or Other Pacific Islander</b>	<b>More than one race reported</b>	<b>Other and Unknown</b>
Total deaths								
Infants 0 to 1	632	363	242	0	27	0	0	0
Children 1 through 4	84	53	27	0	4	0	0	0
Children 5	49	37	10	0	2	0	0	0

through 9								
Children 10 through 14	76	60	15	0	1	0	0	0
Children 15 through 19	297	199	89	0	9	0	0	0
Children 20 through 24	484	322	149	1	12	0	0	0
Children 0 through 24	1622	1034	532	1	55	0	0	0

## Notes - 2011

### Narrative:

The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

**Health Status Indicators 08B:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

<b>CATEGORY</b>	<b>Total NOT Hispanic or Latino</b>	<b>Total Hispanic or Latino</b>	<b>Ethnicity Not Reported</b>
Total deaths			
Infants 0 to 1	488	143	1
Children 1 through 4	67	17	0
Children 5 through 9	43	6	0
Children 10 through 14	57	19	0
Children 15 through 19	258	39	0
Children 20 through 24	410	74	0
Children 0 through 24	1323	298	1

## Notes - 2011

### Narrative:

The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

**Health Status Indicators 09A:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

<b>CATEGORY</b>	<b>Total All Races</b>	<b>White</b>	<b>Black or African American</b>	<b>American Indian or Native Alaskan</b>	<b>Asian</b>	<b>Native Hawaiian or Other Pacific Islander</b>	<b>More than one race reported</b>	<b>Other and Unknown</b>	<b>Specific Reporting Year</b>
Misc Data BY RACE									
All children	2152964	1214107	333412	0	180620	0	420640	4185	2009

0 through 19									
Percent in household headed by single parent	28.0	17.0	61.0	0.0	9.0	0.0	0.0	9.0	2008
Percent in TANF (Grant) families	100.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	2009
Number enrolled in Medicaid	433695	0	0	0	0	0	0	433695	2009
Number enrolled in SCHIP	131556	0	0	0	0	0	0	131556	2009
Number living in foster home care	8831	0	0	0	0	0	0	8831	2008
Number enrolled in food stamp program	253684	0	0	0	0	0	0	253684	2009
Number enrolled in WIC	179937	34042	43526	1068	5439	0	2389	93473	2009
Rate (per 100,000) of juvenile crime arrests	2429.0	0.0	0.0	0.0	0.0	0.0	0.0	2429.0	2008
Percentage of high school drop-outs (grade 9 through 12)	4.0	3.0	5.0	0.0	1.0	0.0	0.0	0.0	2008

#### Notes - 2011

Data Source: US Census county population estimates as of July, 2010 from <http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=NJ&ind=2138>  
White=White, non-Hispanic

Source: National KIDS COUNT Program

<http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=NJ&cat=1326&group=Category&loc=32&dt=1%2c3%2c2%2c4>  
White=White, non-Hispanic

Children Receiving Welfare (Number) – 2009 = 63,556

Data Source: New Jersey Department of Human Services, Division of Family Development  
<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=NJ&ind=2109>

NJ Children in Families Receiving Medicaid (Number) – 2009 = 433,695

Data Provided by: Association for Children of New Jersey  
<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=NJ&ind=2109>

NJ Children Receiving FamilyCare (Number) – 2009 = 131,556

Data Provided by: Association for Children of New Jersey  
<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=NJ&ind=2109>



NJ Children in Families Receiving Food Stamps (Number) – 2009  
 Data Provided by: Association for Children of New Jersey  
<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=NJ&ind=2110>

Source: WIC 2009 Pediatric Nutrition Surveillance Report Table 1C. Children aged < 5 years.

NJ Uniform Crime Report 2008 - 52,684 Juvenile Arrests  
<http://www.state.nj.us/njsp/info/ucr2008/index.html>

Data Provided by: National KIDS COUNT Program  
<http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=NJ&cat=1311&group=Category&loc=32&dt=1%2c3%2c2%2c4>  
 Teens ages 16 to 19 who are not in school and are not high school graduates by race  
 White = white, Non-Hispanic

NJ Children in Out-of-Home Placements (Number) – 2009  
 Data Provided by: Association for Children of New Jersey  
<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=NJ&ind=2125>

#### **Narrative:**

Improving information systems for the various State programs that impact maternal and child health should increase the availability of MCH related data, however issues of standardizing the reporting of race and ethnicity persist. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

**Health Status Indicators 09B:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.*  
 (Demographics)

#### **HSI #09B - Demographics (Miscellaneous Data)**

<b><u>CATEGORY</u></b>	<b>Total NOT Hispanic or Latino</b>	<b>Total Hispanic or Latino</b>	<b>Ethnicity Not Reported</b>	<b>Specific Reporting Year</b>
Miscellaneous Data BY HISPANIC ETHNICITY				
All children 0 through 19	0	436977	0	2009
Percent in household headed by single parent	0.0	41.0	0.0	2008
Percent in TANF (Grant) families	0.0	0.0	100.0	2009
Number enrolled in Medicaid	0	0	433695	2009
Number enrolled in SCHIP	0	0	131556	2009
Number living in foster home care	0	0	8831	2008
Number enrolled in food stamp program	0	0	253684	2009
Number enrolled in WIC	86464	93473	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2429.0	2008
Percentage of high school drop- outs (grade 9 through 12)	0.0	0.0	8.0	2008

#### **Notes - 2011**

Data Source: US Census county population estimates as of July, 2010 from  
<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=NJ&ind=2138>

Children Receiving Welfare (Number) – 2009 = 63,556

Data Source: New Jersey Department of Human Services, Division of Family Development  
<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=NJ&ind=2109>

**Narrative:**

The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

**Health Status Indicators 10:** *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

<b>Geographic Living Area</b>	<b>Total</b>
Living in metropolitan areas	2288504
Living in urban areas	2276759
Living in rural areas	0
Living in frontier areas	0
<b>Total - all children 0 through 19</b>	<b>2276759</b>

**Notes - 2011**

**Narrative:**

New Jersey does not have any designated rural or frontier areas, however New Jersey does have many local areas that create challenges for providing access to services.

**Health Status Indicators 11:** *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

<b>Poverty Levels</b>	<b>Total</b>
Total Population	8663398.0
Percent Below: 50% of poverty	4.2
100% of poverty	9.2
200% of poverty	24.9

**Notes - 2011**

Source: Population Division, U.S. Census Bureau accessed from  
[http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/nj\\_agesex.xls](http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/nj_agesex.xls)

Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement. at  
[http://www.census.gov/hhes/www/cpstables/032009/pov/new46\\_100125\\_01.htm](http://www.census.gov/hhes/www/cpstables/032009/pov/new46_100125_01.htm)  
9.2 +- .8

Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement. at  
[http://www.census.gov/hhes/www/cpstables/032009/pov/new46\\_100125\\_01.htm](http://www.census.gov/hhes/www/cpstables/032009/pov/new46_100125_01.htm)  
24.9 +- 1.1

**Narrative:**

The percent of individuals living in poverty in NJ is growing as a result of the current economic downturn. Providing access and services to MCH services for all individuals is a challenge that requires the timely identification of underserved and uninsured individuals and will require the collaborative efforts of multiple state departments.

**Health Status Indicators 12:** *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

## HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	2276759.0
Percent Below: 50% of poverty	5.0
100% of poverty	13.8
200% of poverty	30.9

**Notes - 2011**

Source: Population Division, US Census Bureau, May 14, 2009.

Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement at [http://www.census.gov/hhes/www/cpstables/032009/pov/new46\\_185200\\_04.htm](http://www.census.gov/hhes/www/cpstables/032009/pov/new46_185200_04.htm)  
POV46: Poverty Status by State: 2008  
< 18 years = 13.8 +/- 1.6

Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement at [http://www.census.gov/hhes/www/cpstables/032009/pov/new46\\_185200\\_04.htm](http://www.census.gov/hhes/www/cpstables/032009/pov/new46_185200_04.htm)  
POV46: Poverty Status by State: 2008  
< 18 years = 30.9 +/- 2.2

**Narrative:**

The percent of children living in poverty in NJ is growing as a result of the current economic downturn. Providing access and services to all children is a challenge that requires the timely identification of underserved and uninsured children and will require the collaborative efforts of multiple state departments.

**F. Other Program Activities**

During FY 2009, the Family Health Line received and assisted 17,850 calls, and made 14,847 referrals. The Reproductive and Perinatal Health Services monitors the grant with the Family Health Line that is a component of the Center for Family Services, Inc. The Reproductive and Perinatal Health Services provides the Family Health Line with consultation, technical assistance and educational material support to facilitate its participation in community events and networking. The Family Health Line employs three clinical staff members who are responsible to answer the Perinatal Mood Disorders Speak Up When You're Down calls. They screen the callers and coordinate working with Mental Health Providers.

**G. Technical Assistance**



## V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>1. Federal Allocation</b> (Line1, Form 2)	11401000	11438007	11685330		11683598	
<b>2. Unobligated Balance</b> (Line2, Form 2)	0	0	0		0	
<b>3. State Funds</b> (Line3, Form 2)	138405877	130964984	130260877		114269877	
<b>4. Local MCH Funds</b> (Line4, Form 2)	0	0	0		0	
<b>5. Other Funds</b> (Line5, Form 2)	0	0	0		0	
<b>6. Program Income</b> (Line6, Form 2)	0	0	0		0	
<b>7. Subtotal</b>	149806877	142402991	141946207		125953475	
<b>8. Other Federal Funds</b> (Line10, Form 2)	45445924	44621750	55818677		66614954	
<b>9. Total</b> (Line11, Form 2)	195252801	187024741	197764884		192568429	

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Federal-State MCH Block Grant Partnership</b>						
<b>a. Pregnant Women</b>	8973485	8177845	9424423		7499733	
<b>b. Infants &lt; 1 year old</b>	5321214	5585540	5222087		5126372	

<b>c. Children 1 to 22 years old</b>	14279510	12200890	15018843		6609841	
<b>d. Children with Special Healthcare Needs</b>	120100089	115340328	111128061		105600037	
<b>e. Others</b>	0	0	0		0	
<b>f. Administration</b>	1132579	1098388	1152793		1117492	
<b>g. SUBTOTAL</b>	149806877	142402991	141946207		125953475	
<b>II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).</b>						
<b>a. SPRANS</b>	0		0		0	
<b>b. SSDI</b>	132836		94644		93713	
<b>c. CISS</b>	140000		105000		132000	
<b>d. Abstinence Education</b>	0		0		0	
<b>e. Healthy Start</b>	500000		500000		500000	
<b>f. EMSC</b>	0		0		0	
<b>g. WIC</b>	23885700		33275457		42885265	
<b>h. AIDS</b>	2283000		2260049		2260049	
<b>i. CDC</b>	1295357		3224471		3822731	
<b>j. Education</b>	11066631		10865873		10865873	
<b>k. Other</b>						
<b>Family Planning</b>	0		3413730		3534841	
<b>Others</b>	0		2079453		2520482	
<b>CDC Lead</b>	1105400		0		0	
<b>Hearing</b>	220000		0		0	
<b>OPA</b>	2895000		0		0	
<b>SSBG</b>	1922000		0		0	

**Form 5, State Title V Program Budget and Expenditures by Types of Services (II)**

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Direct Health Care Services</b>	111414100	106651905	107316193		88460440	
<b>II. Enabling Services</b>	20584077	18871286	18174577		18329977	
<b>III. Population-Based Services</b>	10320500	8862202	9561400		12459391	
<b>IV. Infrastructure Building Services</b>	7488200	8017598	6894037		6703667	
<b>V. Federal-State Title V Block Grant Partnership Total</b>	149806877	142402991	141946207		125953475	

## A. Expenditures

Annual expenditures are summarized in below. The State Title V Programs Budget and Expenditures by Types of Service, parallels the MCH pyramid which organizes MCH Services hierarchically from direct health care services through infrastructure building services.

## B. Budget

New Jersey has traditionally maintained commitment of State funding support for maternal and child health activities. Since 1989, maintenance of effort has included State appropriations for children with special health care needs and support for population based outreach and education for pregnant women and their infants to name a few.

State appropriations support a number of maternal and child health programs. In the State fiscal year 2011 budget most programs and services are maintained at the SFY 2010 levels. Due to the continuing state fiscal crisis, the proposed SFY 2011 budget includes reductions in a few service areas including postpartum depression education, early intervention, and the elimination of state funding for family planning. However, based on the critical nature of the budget deficit in the state the proposed budget demonstrates an ongoing commitment on the part of the State to support to the best of its ability services to the maternal and child health population. Since the State budget will not be finalized until June 30, 2010, the following are the proposed funding levels for programs and services for FFY 2011 that reach maternal and child health populations in New Jersey:

Birth Defects Registry	\$ 564,000
Cleft lip and palate projects	\$ 693,000
Family Planning Services	\$
Infant mortality reduction including a new project focused on reduction of black infant mortality	\$ 2,500,000
Sudden Infant Death Syndrome	\$ 221,000
Newborn screening (revenue)	\$ 3,306,000
Postpartum Depression education	\$ 450,000
Postpartum Depression screening and referral	\$ 1,900,000
Early intervention for developmental delay/disabilities	\$ 86,648,000
Childhood lead poisoning prevention	\$ 987,000
Hemophilia services	\$ 1,245,000
Catastrophic illness in children relief fund	\$ 1,606,877
Handicapped children's fund, which is used to support subspecialty care and case management services	\$ 2,516,000
Fetal Alcohol Syndrome	\$ 570,000
MCH Services	\$ 5,513,000
Council Physical Fitness and Sports	\$ 50,000
Autism Registry	\$ 500,000
Governor's Council on Autism Research	\$ 5,000,000

All of the funding sources are considered in the programmatic narrative portion of this application. There have been few variations in the allocation and expenditure of the federal/state partnership funds for maternal and child health over the last few years. This year state appropriations do not include cost of living increases and reductions are evident in a few areas including family planning and early intervention.

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section "New State Performance Measure Detail Sheets and Data.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.